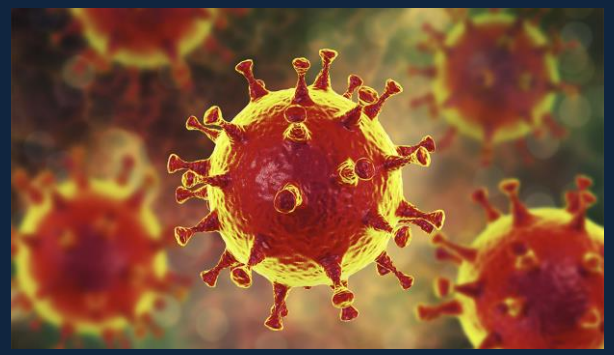
HOSPITAL SANTIAGO ORIENTE
DR. LUIS TISNÉ BROUSSE



CUIDADOS PALIATIVOS EN PANDEMIA COVID

DR. RAIMUNDO CORREA B.
GINECÓLOGO ONCÓLOGO
SUB – ESPECIALISTA EN CUIDADOS PALIATIVOS
HOSPITAL SANTIAGO ORIENTE – CLINICA LAS CONDES
CERPO – JUNIO 2020

INTRODUCCIÓN

- Concepto de Cuidados Paliativos/Soporte Oncológico.
- Beneficios en el Tiempo.
- Organismos Internacionales.
- Rol de los Cuid Paliativos en Pandemia COVID - 19.

DEFINICIÓN

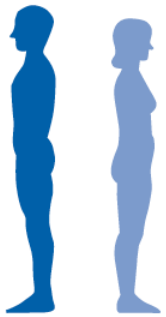
ENFRENTAMIENTO QUE MEJORA LA CALIDAD DE VIDA DE PACIENTES Y FAMILIARES QUE SE ENFRENTAN AL PROBLEMA DE UNA ENFERMEDAD INCURABLE, A TRAVES DE LA PREVENCION Y EL ALIVIO DE SINTOMAS MEDIANTE LA IDENTIFICACION PRECOZ Y UNA IMPECABLE EVALUACION Y TRATAMIENTO DEL DOLOR Y OTROS PROBLEMAS, FÍSICOS, PSICOLOGICOS Y ESPIRITUALES.

CONFLICTO DE INTERÉS

Figure 3. Leading Sites of New Cancer Cases and Deaths – 2018 Estimates

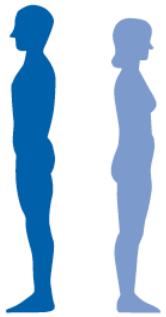
Estimated New Cases

Male			Female		
Prostate	164,690	19%	Breast	266,120	30%
Lung & bronchus	121,680	14%	Lung & bronchus	112,350	13%
Colon & rectum	75,610	9%	Colon & rectum	64,640	7%
Urinary bladder	62,380	7%	Uterine corpus	63,230	7%
Melanoma of the skin	55,150	6%	Thyroid	40,900	5%
Kidney & renal pelvis	42,680	5%	Melanoma of the skin	36,120	4%
Non-Hodgkin lymphoma	41,730	5%	Non-Hodgkin lymphoma	32,950	4%
Oral cavity & pharynx	37,160	4%	Pancreas	26,240	3%
Leukemia	35,030	4%	Leukemia	25,270	3%
Liver & intrahepatic bile duct	30,610	4%	Kidney & renal pelvis	22,660	3%
All sites	**856,370**	**100%**	**All sites**	**878,980**	**100%**

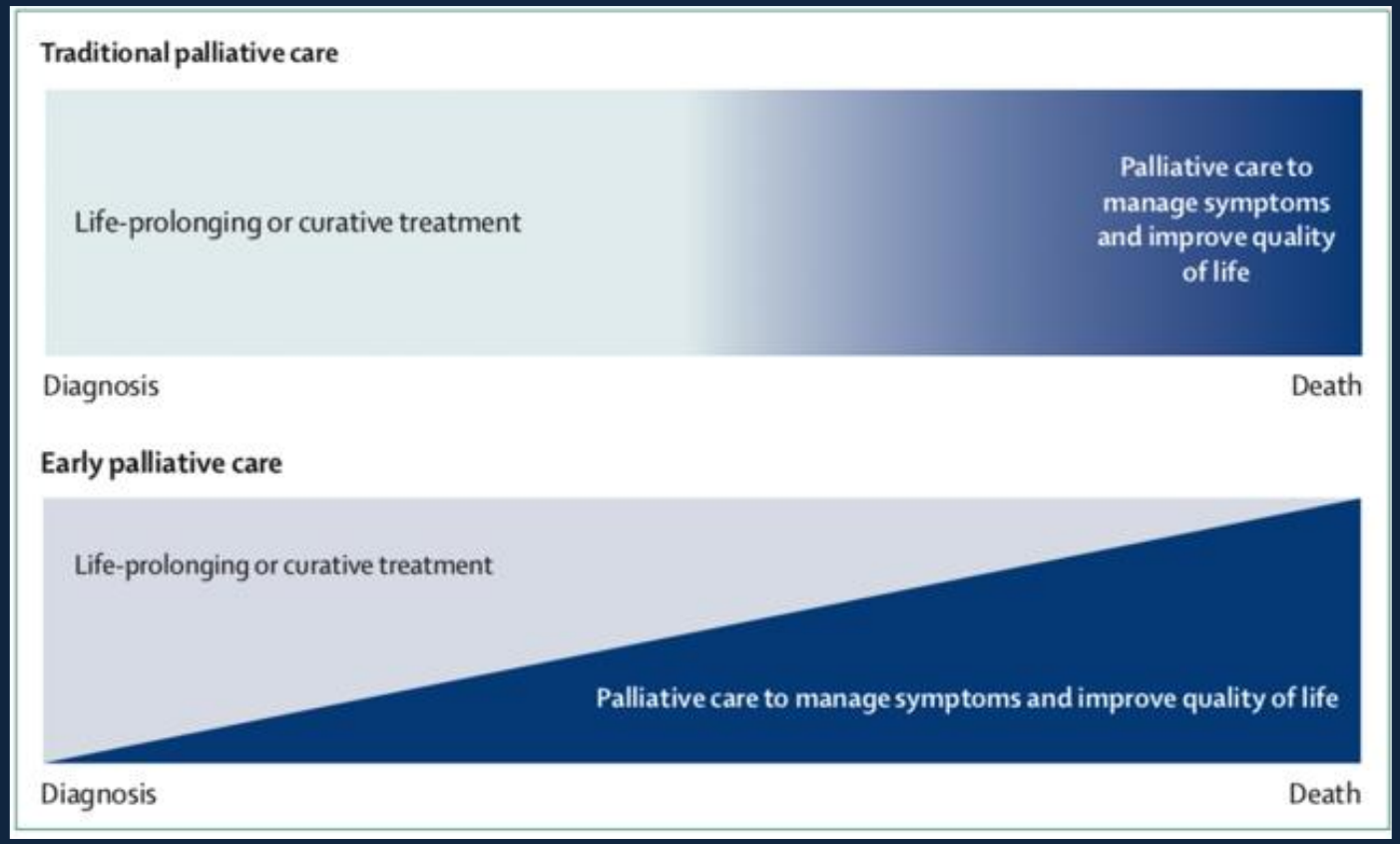


Estimated Deaths

Male			Female		
Lung & bronchus	83,550	26%	Lung & bronchus	70,500	25%
Prostate	29,430	9%	Breast	40,920	14%
Colon & rectum	27,390	8%	Colon & rectum	23,240	8%
Pancreas	23,020	7%	Pancreas	21,310	7%
Liver & intrahepatic bile duct	20,540	6%	Ovary	14,070	5%
Leukemia	14,270	4%	Uterine corpus	11,350	4%
Esophagus	12,850	4%	Leukemia	10,100	4%
Urinary bladder	12,520	4%	Liver & intrahepatic bile duct	9,660	3%
Non-Hodgkin lymphoma	11,510	4%	Non-Hodgkin lymphoma	8,400	3%
Kidney & renal pelvis	10,010	3%	Brain & other nervous system	7,340	3%
All sites	**323,630**	**100%**	**All sites**	**286,010**	**100%**



Estimates are rounded to the nearest 10, and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. Ranking is based on modeled projections and may differ from the most recent observed data.



www.thelancet.com/oncology Vol 19 November 2018

SIXTY-SEVENTH WORLD HEALTH ASSEMBLY **WHA67.19**

Agenda item 15.5 **24 May 2014**

Strengthening of palliative care as a component of comprehensive care throughout the life course

The Sixty-seventh World Health Assembly,

Having considered the report on strengthening of palliative care as a component of integrated treatment throughout the life course;[1]

Recalling resolution WHA58.22 on cancer prevention and control, especially as it relates to palliative care;

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2019
Palliative Care

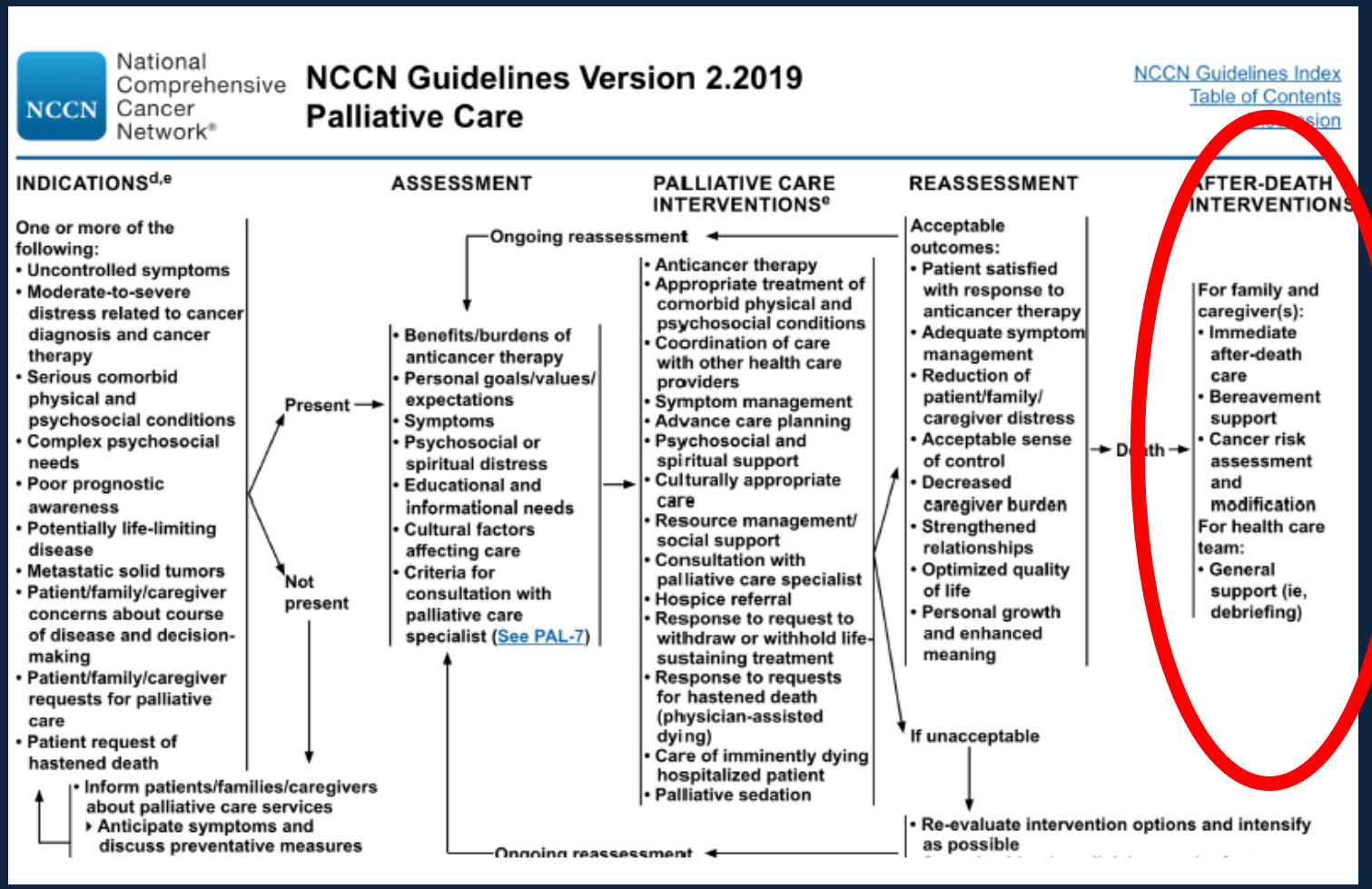
NCCN Guidelines Index
Table of Contents
Discussion

Definition of Palliative Care[a,c]

Palliative care is an approach to patient/family/caregiver-centered health care that focuses on optimal management of distressing symptoms, while incorporating psychosocial and spiritual care according to patient/family/caregiver needs, values, beliefs, and cultures. The goal of palliative care is to anticipate, prevent, and reduce suffering and to support the best possible quality of life for patients/families/caregivers, [illegible] concurrently with disease-directed, life-prolonging therapies and should facilitate patient autonomy, access to information, and choice. Palliative care becomes the main focus of care when disease-directed, life-prolonging therapies are no longer effective, appropriate, or desired. Palliative care should be provided by the primary oncology team and augmented as needed by collaboration with an interdisciplinary team of palliative care experts.

Standards of Palliative Care[b,c]

- Institutions should develop processes for integrating palliative care into cancer care, both as part of usual oncology care and for patients with specialty palliative care needs.
- All cancer patients should be screened for palliative care needs at their initial visit, at appropriate intervals, and as clinically indicated.
- Patients/families/caregivers should be informed that palliative care is an integral part of their comprehensive cancer care.
- Educational programs should be provided to all health care professionals and trainees so that they can develop effective palliative care knowledge, skills, and attitudes.
- Palliative care specialists and interdisciplinary palliative care teams, including board-certified palliative care physicians, advanced practice nurses, physician assistants, social workers, chaplains, and pharmacists, should be readily available to provide consultative or direct care to patients/families/caregivers and/or health care professionals who request or require their expertise.
- Quality of palliative care should be monitored by institutional quality improvement programs.


NCCN
National Comprehensive Cancer Network®
NCCN Guidelines Version 2.2019
Palliative Care
NCCN Guidelines Index
Table of Contents
INDICATIONS[d,e]
ASSESSMENT
PALLIATIVE CARE INTERVENTIONS[e]
REASSESSMENT
AFTER-DEATH INTERVENTIONS
One or more of the following:
• Uncontrolled symptoms
• Moderate-to-severe distress related to cancer diagnosis and cancer therapy
• Serious comorbid physical and psychosocial conditions
• Complex psychosocial needs
• Poor prognostic awareness
• Potentially life-limiting disease
• Metastatic solid tumors
• Patient/family/caregiver concerns about course of disease and decision-making
• Patient/family/caregiver requests for palliative care
• Patient request of hastened death
Present
Not present
Ongoing reassessment
• Benefits/burdens of anticancer therapy
• Personal goals/values/expectations
• Symptoms
• Psychosocial or spiritual distress
• Educational and informational needs
• Cultural factors affecting care
• Criteria for consultation with palliative care specialist (See PAL-7)
• Anticancer therapy
• Appropriate treatment of comorbid physical and psychosocial conditions
• Coordination of care with other health care providers
• Symptom management
• Advance care planning
• Psychosocial and spiritual support
• Culturally appropriate care
• Resource management/social support
• Consultation with palliative care specialist
• Hospice referral
• Response to request to withdraw or withhold life-sustaining treatment
• Response to requests for hastened death (physician-assisted dying)
• Care of imminently dying hospitalized patient
• Palliative sedation
Acceptable outcomes:
• Patient satisfied with response to anticancer therapy
• Adequate symptom management
• Reduction of patient/family/caregiver distress
• Acceptable sense of control
• Decreased caregiver burden
• Strengthened relationships
• Optimized quality of life
• Personal growth and enhanced meaning
Death
For family and caregiver(s):
• Immediate after-death care
• Bereavement support
• Cancer risk assessment and modification
For health care team:
• General support (ie, debriefing)
If unacceptable
• Re-evaluate intervention options and intensify as possible
Ongoing reassessment
• Inform patients/families/caregivers about palliative care services
• Anticipate symptoms and discuss preventative measures

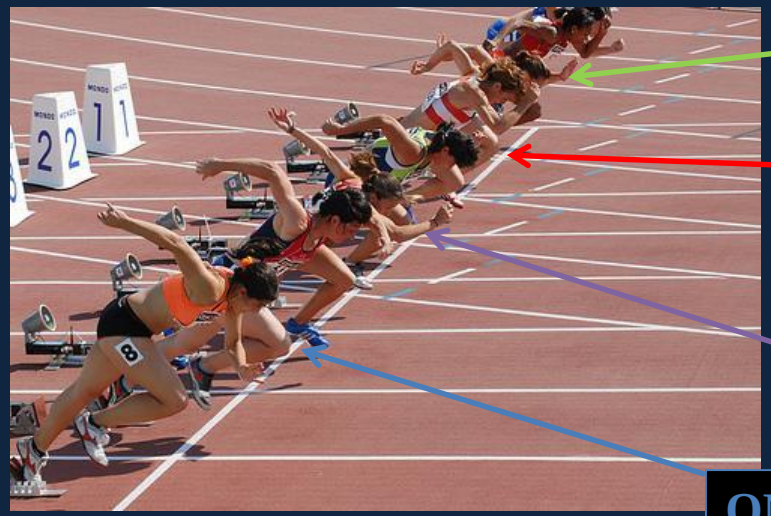
DIAGNÓSTICO

TRATAMIENTO ESPECÍFICO

SOPORTE ONCOLÓGICO

RENCURRENCIA / PROGRESIÓN

SOPORTE ONCOLÓGICO



SOPORTE ONCOLÓGICO

RADIOTERAPIA

ONCOLOGÍA MÉDICA

ONCOLOGÍA QUIRÚRGICA

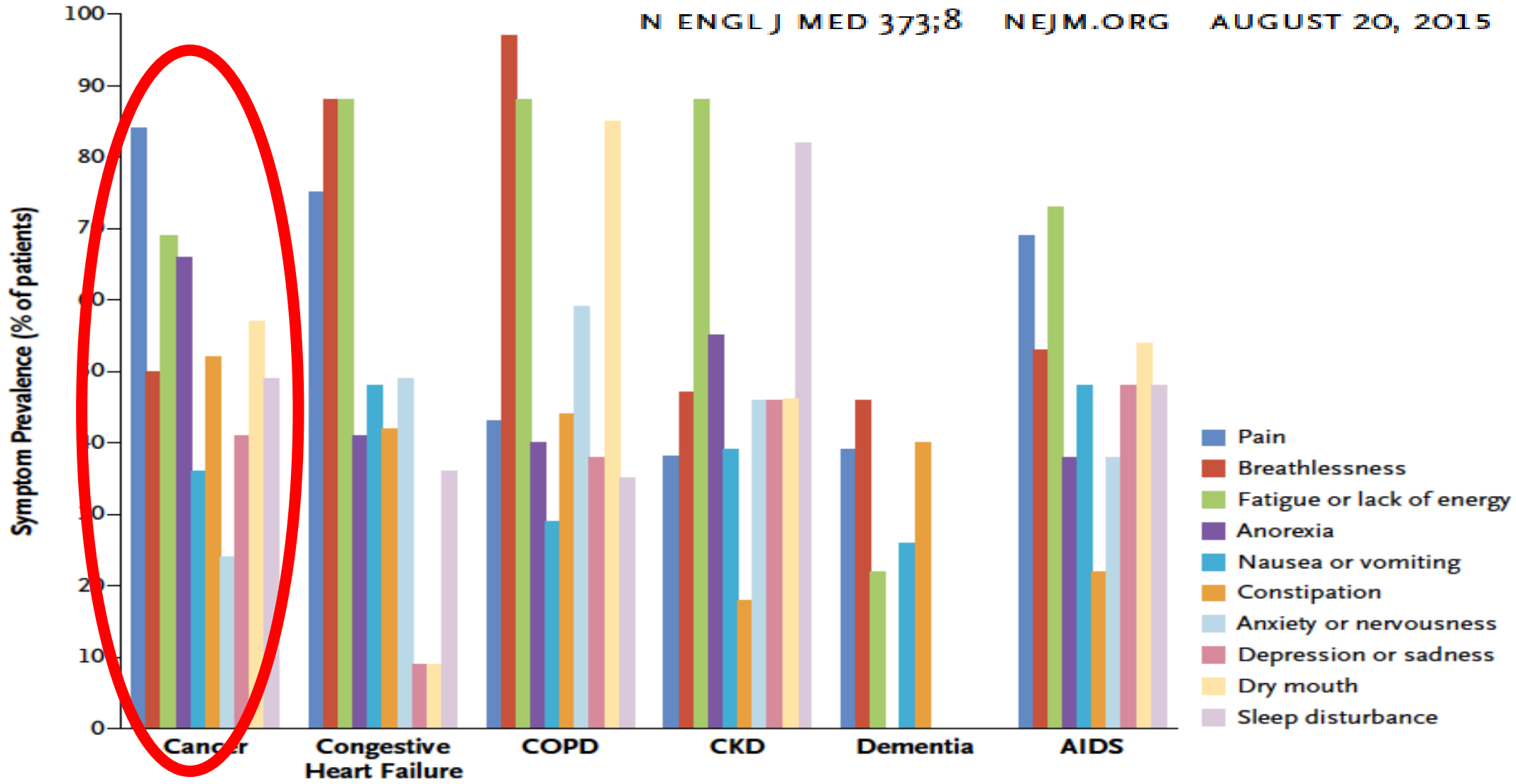


Figure 1. Symptom Prevalence in Advanced Illness.

Data are from representative studies of symptom prevalence among patients with cancer,[8-12] congestive heart failure,[13,14] chronic obstructive pulmonary disease (COPD),[15] chronic kidney disease (CKD),[13,14] or dementia[16,17] and among patients who received highly active antiretroviral therapy for the acquired immunodeficiency syndrome (AIDS).[18] Self-reported data regarding some symptoms were unavailable for patients with dementia.

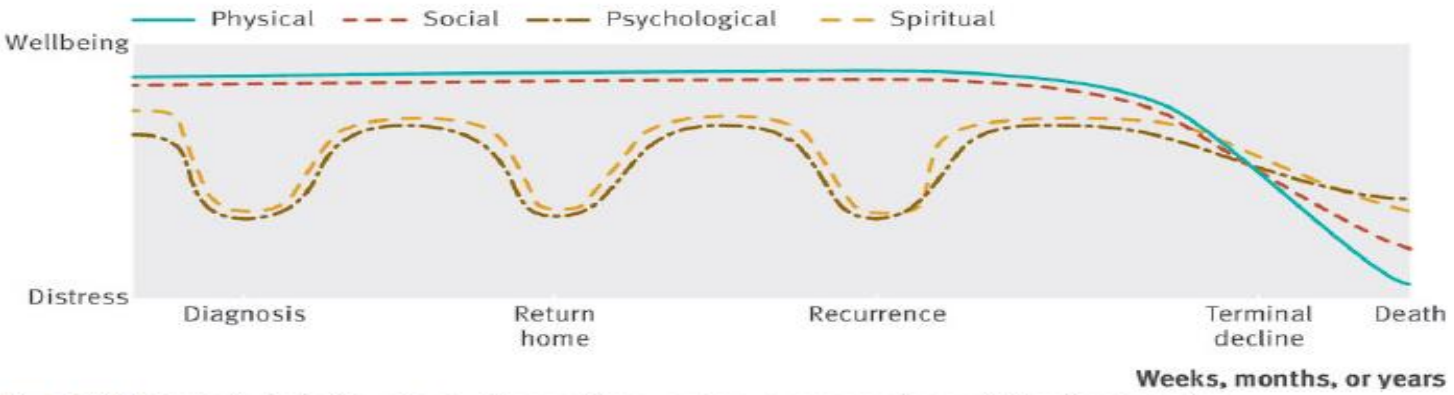


Fig 1 Wellbeing trajectories in patients with conditions such as cancer causing rapid functional decline

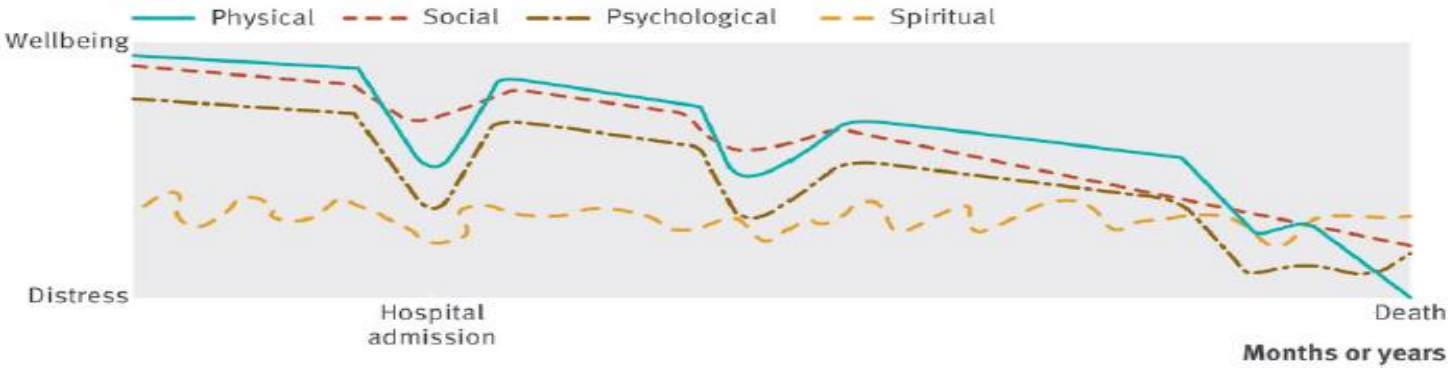


Fig 2 Wellbeing trajectories in patients with intermittent decline (typically organ failure or multimorbidity)

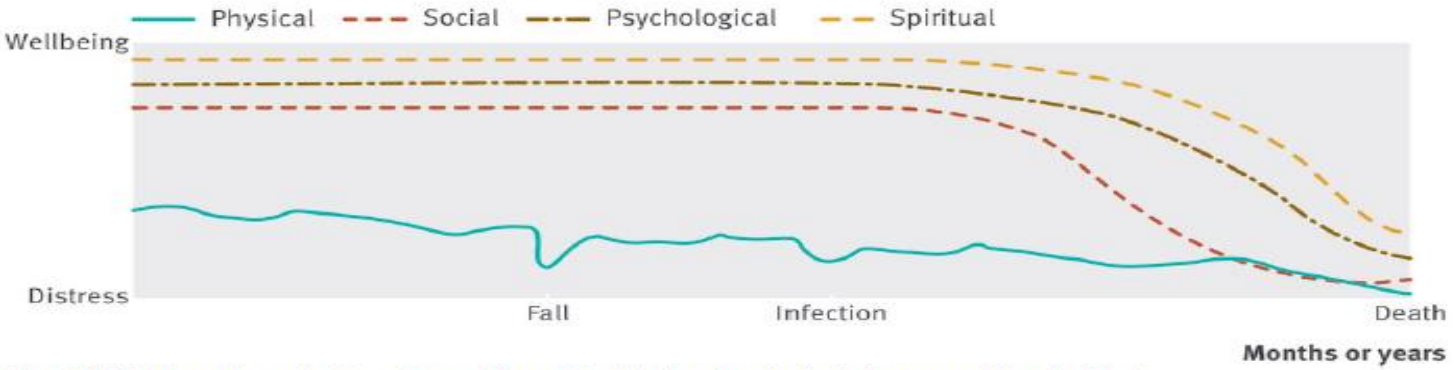


Fig 3 Wellbeing trajectories in patients with gradual decline (typically frailty or cognitive decline)

BMJ 2017

EQUIPO MULTIDISCIPLINARIO

- Médico.
- Enfermera.
- Psicólogo.
- Nutricionista.
- Químico Farmaceuta
- Terapeuta Ocupacional/Kinesiólogo.
- Trabajador Social.
- Soporte Espiritual.
- Voluntariado.
- **MUCHOS OTROS.**

Cochrane Library

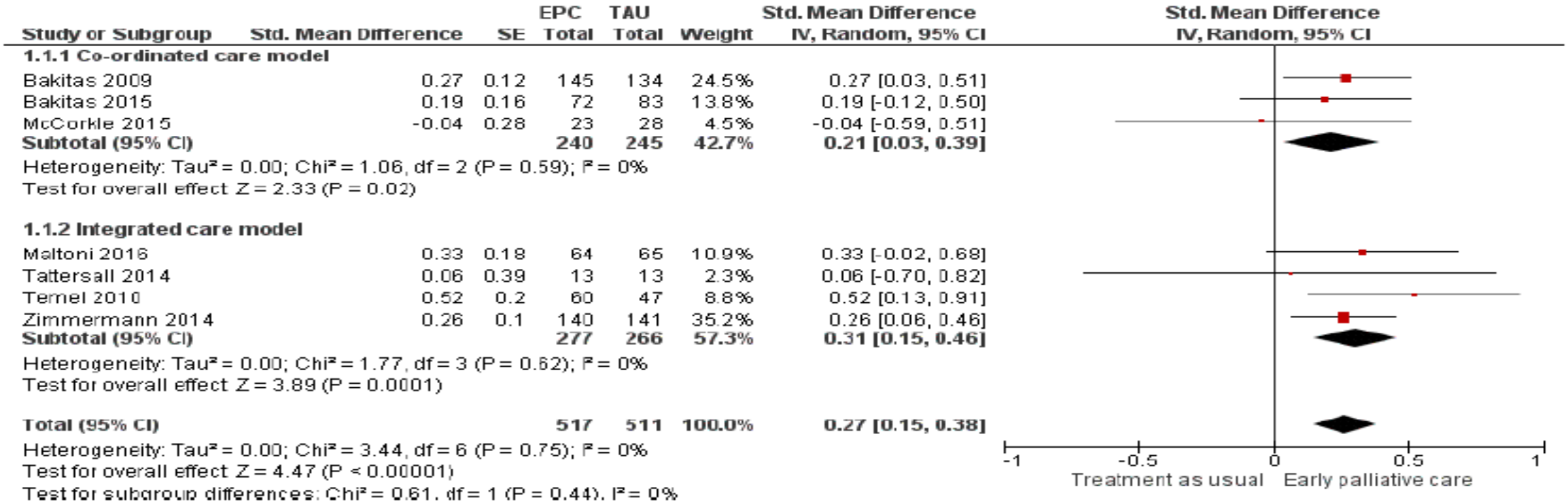
Cochrane Database of Systematic Reviews

Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rücker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

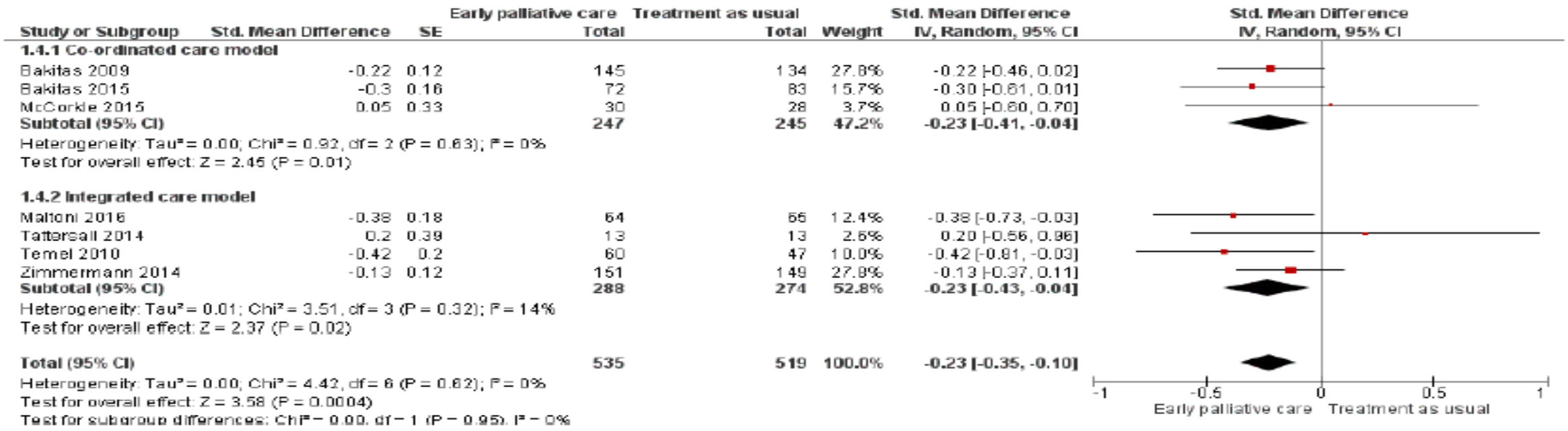
Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD011129.
DOI: 10.1002/14651858.CD011129.pub2.

Figure 4. Forest plot of comparison: 1 Health-related quality of life, outcome: 1.1 Health-related quality of life.



Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD011129.
DOI: 10.1002/14651858.CD011129.pub2.

Figure 7. Forest plot of comparison: 1 Early palliative care vs standard oncological care, outcome: 1.4 Symptom intensity.



Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD011129.
DOI: 10.1002/14651858.CD011129.pub2.

Figure 5. Forest plot of comparison: 1 Early palliative care vs TAU, outcome: 1.2 Survival.

Study or Subgroup	log[Hazard Ratio]	SE	Treatment as usual Total	Early palliative care Total	Weight	Hazard Ratio IV, Random, 95% CI
Bakitas 2009	-0.22	0.15	161	161	26.6%	0.80 [0.60, 1.08]
Bakitas 2015	-0.45	0.21	103	104	23.7%	0.64 [0.42, 0.96]
Tattersall 2014	0.47	0.19	60	60	24.8%	1.60 [1.10, 2.32]
Temel 2010	-0.46	0.19	74	77	24.8%	0.63 [0.44, 0.92]
Total (95% CI)			**398**	**402**	**100.0%**	**0.85 [0.56, 1.28]**

Heterogeneity: Tau² = 0.14; Chi² = 15.55, df = 3 (P = 0.001); I² = 81%
Test for overall effect: Z = 0.78 (P = 0.43)

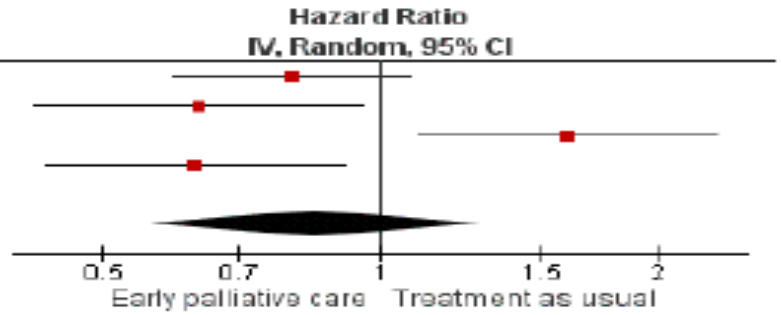
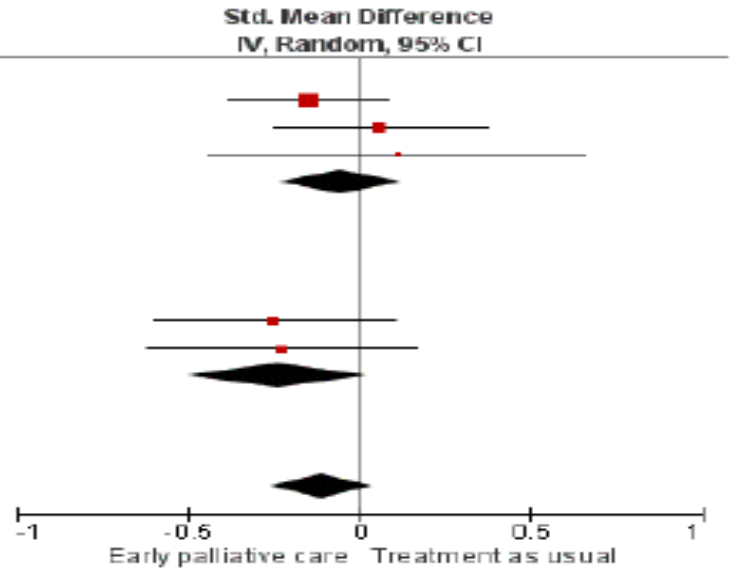


Figure 6. Forest plot of comparison: 1 Early palliative care vs standard oncological care, outcome: 1.2 Depression.

Study or Subgroup	Std. Mean Difference	SE	Treatment as usual Total	Early palliative care Total	Weight	Std. Mean Difference IV, Random, 95% CI
1.2.1 Co-ordinated care model						
Bakitas 2009	-0.15	0.12	134	145	39.2%	-0.15 [-0.39, 0.09]
Bakitas 2015	0.06	0.16	83	72	22.1%	0.06 [-0.25, 0.37]
McCorkle 2015	0.11	0.28	56	36	7.2%	0.11 [-0.44, 0.66]
Subtotal (95% CI)			**273**	**253**	**68.5%**	**-0.06 [-0.23, 0.12]**
Heterogeneity: Tau² = 0.00; Chi² = 1.49, df = 2 (P = 0.47); I² = 0%						
Test for overall effect: Z = 0.61 (P = 0.54)						
1.2.2 Integrated care model						
Maltoni 2016	-0.25	0.18	65	64	17.4%	-0.25 [-0.60, 0.10]
Temel 2010	-0.23	0.2	47	60	14.1%	-0.23 [-0.62, 0.16]
Subtotal (95% CI)			**112**	**124**	**31.5%**	**-0.24 [-0.50, 0.02]**
Heterogeneity: Tau² = 0.00; Chi² = 0.01, df = 1 (P = 0.94); I² = 0%						
Test for overall effect: Z = 1.80 (P = 0.07)						
Total (95% CI)			**385**	**377**	**100.0%**	**-0.11 [-0.26, 0.03]**
Heterogeneity: Tau² = 0.00; Chi² = 2.82, df = 4 (P = 0.59); I² = 0%						
Test for overall effect: Z = 1.51 (P = 0.13)						
Test for subgroup differences: Chi² = 1.32, df = 1 (P = 0.25), I² = 24.5%						



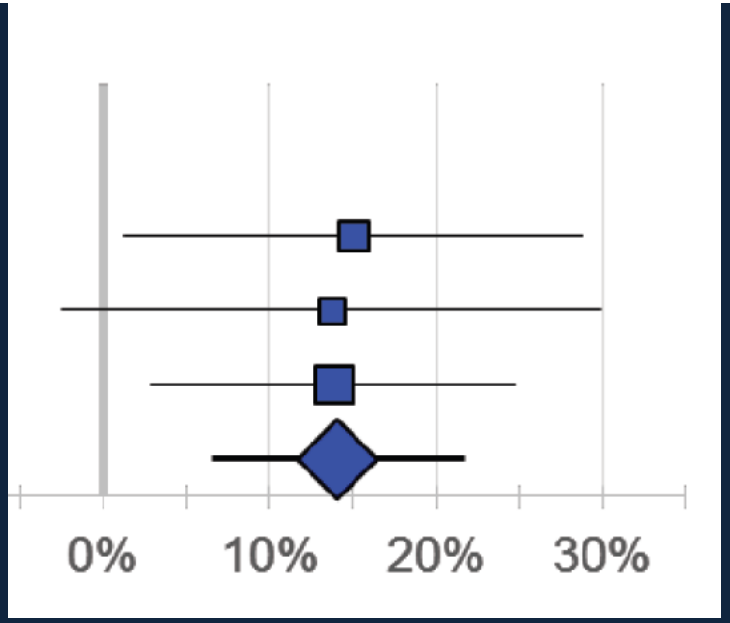
Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD011129.
DOI: 10.1002/14651858.CD011129.pub2.

ann. behav. med. (2019) 53:674–685
DOI: 10.1093/abm/kay077

REGULAR ARTICLE

Impact of Interdisciplinary Outpatient Specialty Palliative Care on Survival and Quality of Life in Adults With Advanced Cancer: A Meta-Analysis of Randomized Controlled Trials

Michael Hoerger, PhD, MSCR[1] • Graceanne R. Wayser, MPH[2] • Gregory Schwing, BS[3] • Ayako Suzuki, MD, MPH[2] • Laura M. Perry, MS[4]



MANEJO DEL PACIENTE

ENFERMEDAD

- Biología de ella.
- Opciones de tratamiento (incl riesgos/beneficios).
- Capacidad para realizar tratamientos personalizados.

SOPORTE

- Enfrentamiento adecuado de los síntomas y su manejo respectivo.
- Terapia psicológica.
- Comunicación (pronóstico, fin de vida).
- Planificar el cuidado.
- Cuidado de fin de vida/duelo.

Hui et al. JCO, 2015

SOPORTE ONCOLÓGICO/CUIDADOS PALIATIVOS Y CÁNCER DE MAMA

TERAPIA

A. Cirugía.

B. Quimioterapia:

-Dolor Neuropático.

C. Radioterapia:

-Enfermedad Actínica.

-Linfedema.

ENFERMEDAD AVANZADA

A. Síntomas Generales.

B. Síntomas Específicos:

-Metástasis Óseas/Cerebrales.

-Nódulo/Aumento de Volumen Mamario:

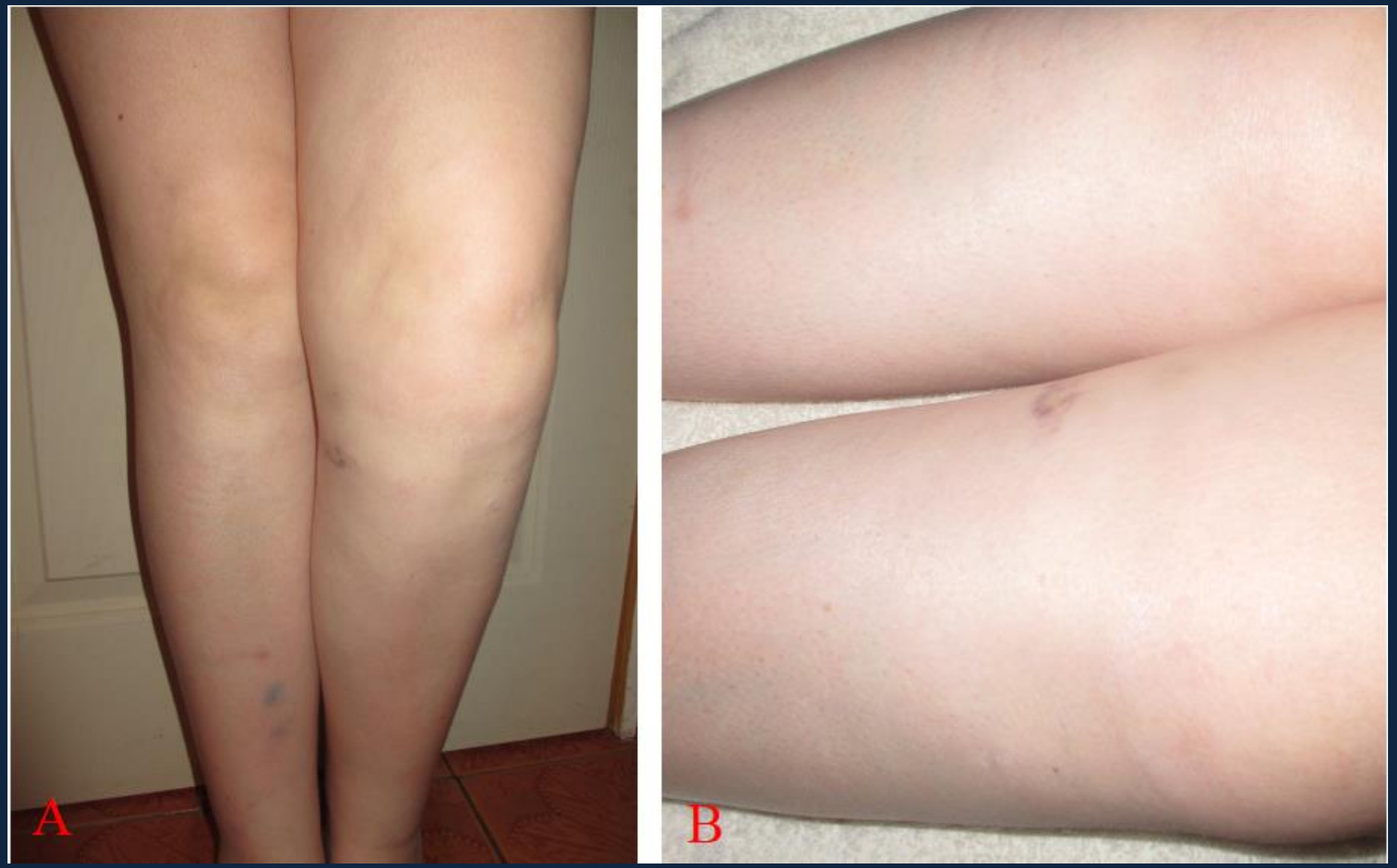
-Ulcerada.

-Mal Olor.

-Hemorragia.

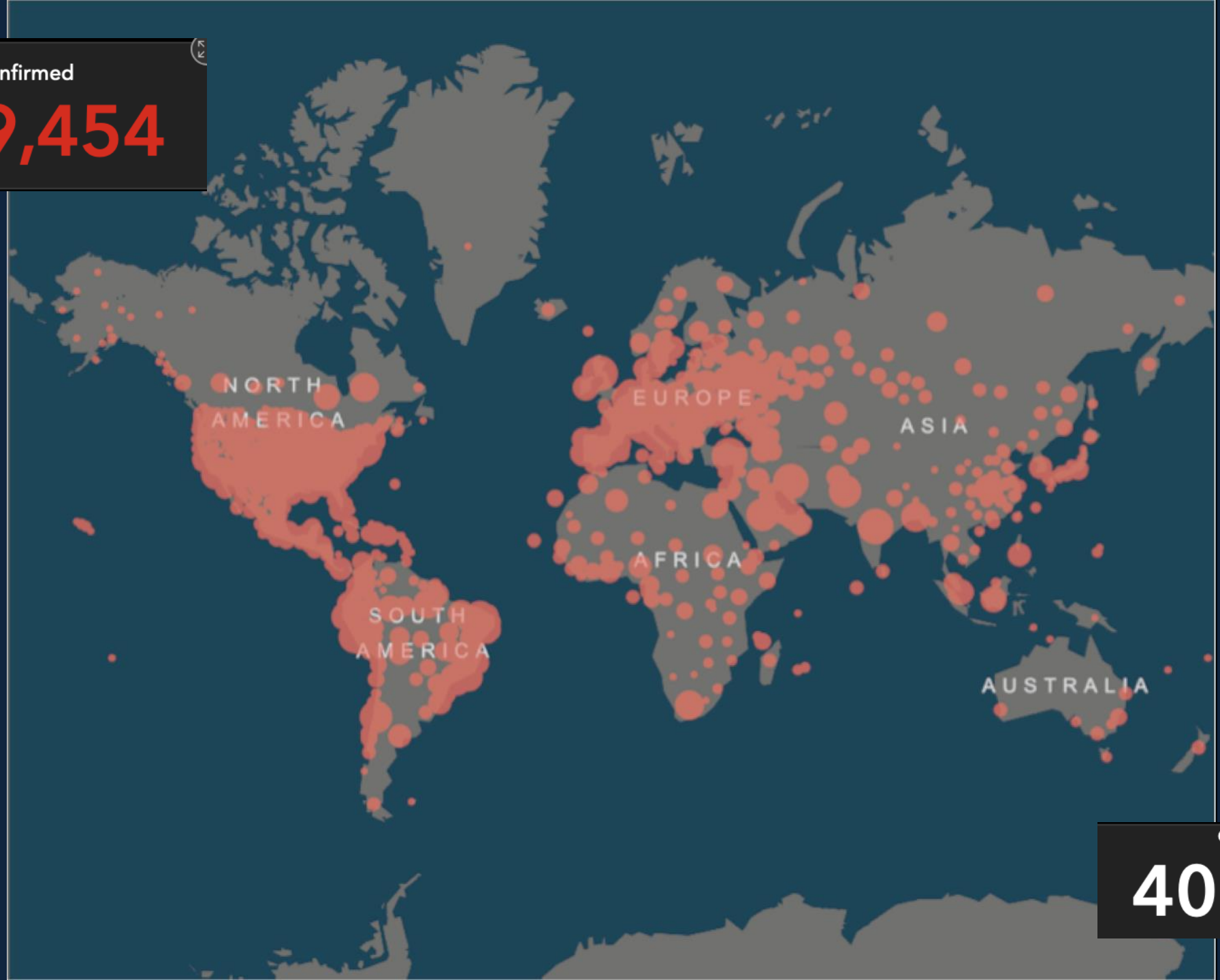
-Metastásis Ganglionares:

-Síndrome de Vena Cava Superior.


A
B

Total Confirmed

7,119,454



Global Deaths

406,540

RESOLUCIÓN OMS 18 MAYO 2020

PANDEMIA COVID

- Casos Nuevos: 138.846.
- Fallecidos: 2.264 (1.63%).
- RM (%casos/%fallecidos): 80.6%/86.13%.
- Comunas:
  - Puente Alto.
  - Santiago.
  - **Peñalolén.**

EFECTOS

- Alta ocupación de camas críticas (encuesta diaria de Soc Chil de Med Intensiva).
- Redistribución de Camas Críticas.
- Servicios de Urgencia colapsados.
- Foco sólo COVID, cancelación de cirugías oncológicas, etc.
- Nuestro Hospital.

PROTOCOLO PANDEMIA COVID Y CUIDADOS PALIATIVOS
HOSPITAL SANTIAGO ORIENTE – DR. LUIS TISNÉ B.

MARCO TEÓRICO

La pandemia causada por el virus SARS-CoV-2, también conocido como COVID 19 o coronavirus, está causando a nivel mundial un gran número de personas infectadas y, lamentablemente, un alto número de fallecidos producto de esta misma causa. De acuerdo a los datos entregados por la Universidad de Johns Hopkins, al 03 de Junio de 2020, el número de pacientes infectados en el mundo es de 6.635.004, mientras que el número de fallecidos asciende a 391.179 personas. Basado en estos datos, la letalidad de este germen, a nivel mundial, es de un 5.9%.

PROYECTO

- Grupo de Riesgo.
- Mortalidad Asociada.
- Pacientes Hospitalizados.
- Muerte Digna.
- Comunicación con Familias.

INTEGRANTES

- Médicos/Becados.
- Matronas/TENS.
- Kinesiólogos.
- Asistente Social.
- Sacerdote.
- Psicólogos/Psiquiátras.

PROYECTO

- Inicio: Martes 2 de Junio.
- Sala Especial 4 camas.
- Pacientes “Satélites” ocasionales.
- 17 pacientes/ 9 fallecidos.
- Excelente comunicación con familia.
- Dificultades.

CONSIDERACIONES FINALES

- El cuidado de un paciente en final de vida representa un derecho humano ineludible para todo profesional de la salud.

- Pacientes enfrentados a infección por SARS-CoV-2 no son la excepción. .

- En condiciones de pandemia, la puesta en marcha de una sala de final de vida ha sido una experiencia que asegura una muerte más digna, en un ambiente más tranquilo y con una adecuada aceptación de las familias (data muy inicial, un solo centro).

- Fundamental el cuidado del equipo.

MUCHAS GRACIAS