Como prepararse para la oncología del S XXI: En lo relativo al uso de nuevas Tecnologías

X Curso SEOM para residentes de manejo de síntomas y terapia de soporte en el paciente oncológico

Alfonso Berrocal
Servicio Oncología Medica
Hospital General Universitario Valencia

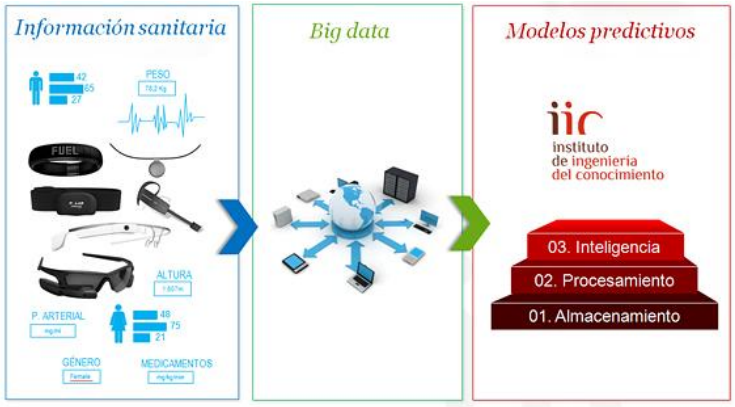
La información

- Vivimos en un mundo de información creciente
  - En el 2015 la información se duplico cada 35 días
  - Los nuevos clínicos deberán ser capaces de procesar una avalancha de información durante su carrera
  - El aprendizaje de cómo manejar esta información es por tanto critico

El formato digital

- En la actualidad se tiende a digitalizar toda la información
  - La historia clínica
  - Los libros
  - Las publicaciones científicas
  - Las actividades docentes
    - Académicas
    - Basadas en web
  - Nuevos recursos educativos
    - Blogs
    - Wikis
    - Podcast
    - Aprendizaje virtual

Big Data y Oncología



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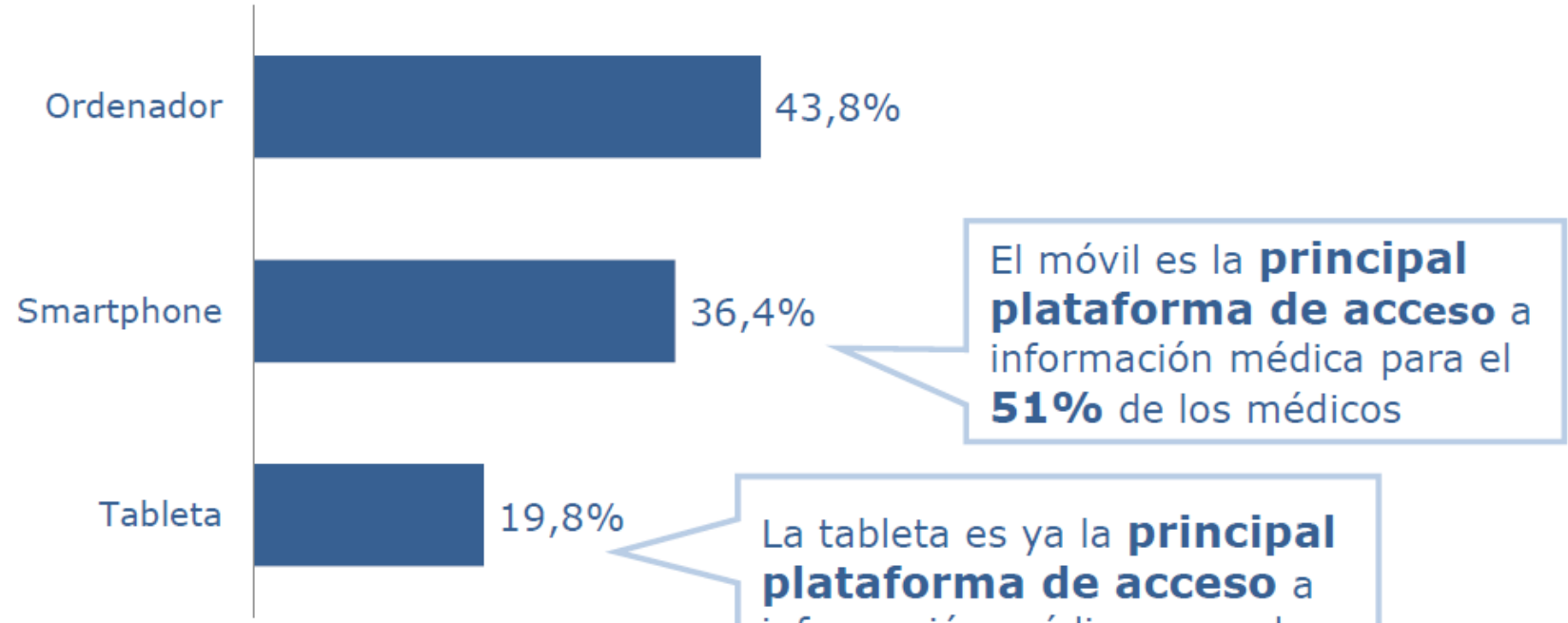
- Los nuevos alumnos son “nativos digitales”
  - Han crecido en un mundo de información digital
- Los docentes son “colonos digitales”
  - No son “digitales de nacimiento”
  - En la actualidad “viven en digital”

Los nuevos docentes

- Deben incorporar nuevas tecnologías sin reemplazar la comunicación cara a cara, deben dar soporte.
- Deben establecer objetivos docentes y no dejar todo a las tecnologías
- Se debe facilitar amplia variedad de material
- Deben apoyar el desarrollo de tecnologías educativas

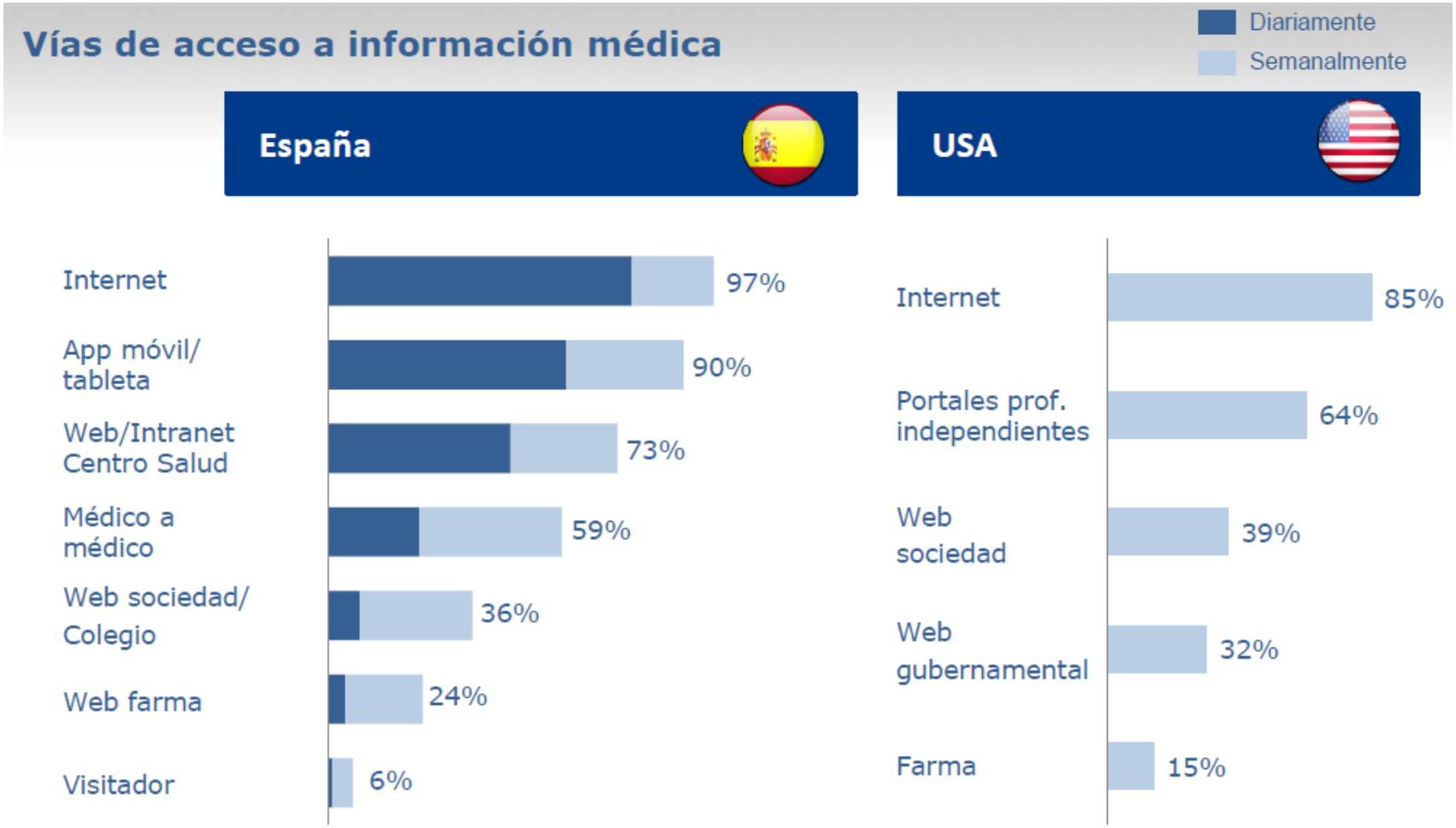
Como se accede a la información

Porcentaje de tiempo por dispositivo de acceso



Fuente: I Estudio iDoctus – SEMG "Hábitos digitales del médico general y de familia español" (N=447)

¿Donde buscamos la información?



Fuente: I Estudio iDoctus – SEMG "Hábitos digitales del médico general y de familia español" (N=455); Manhattan Research Taking the Pulse 2012

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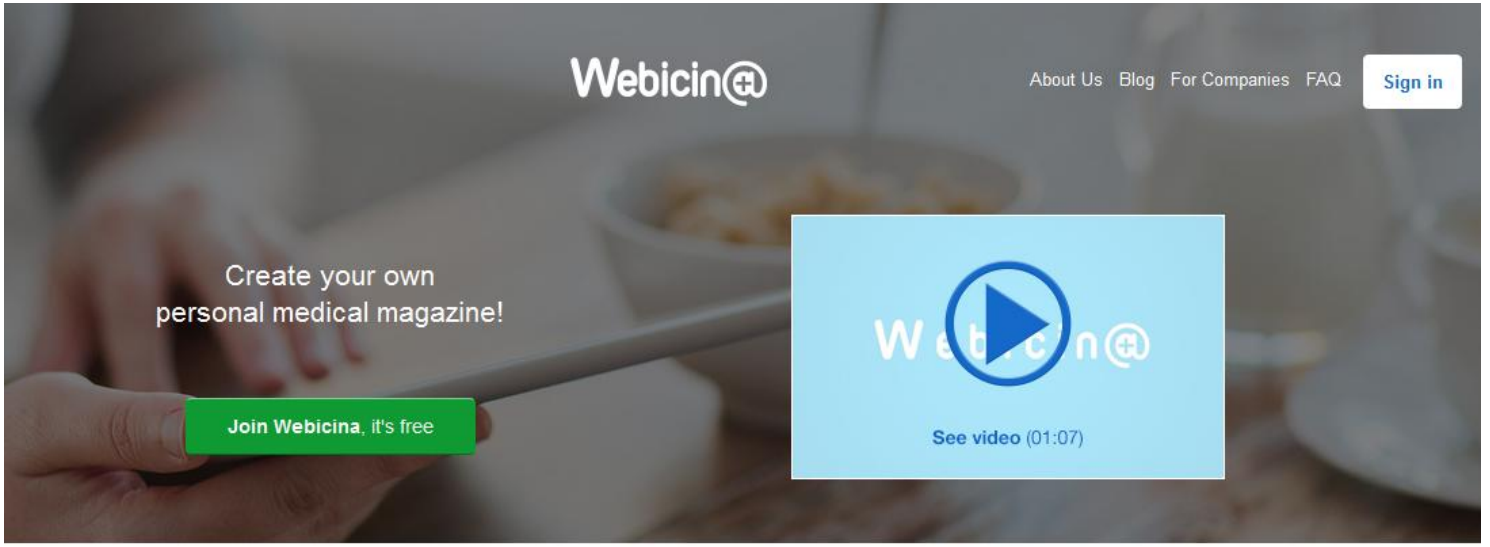

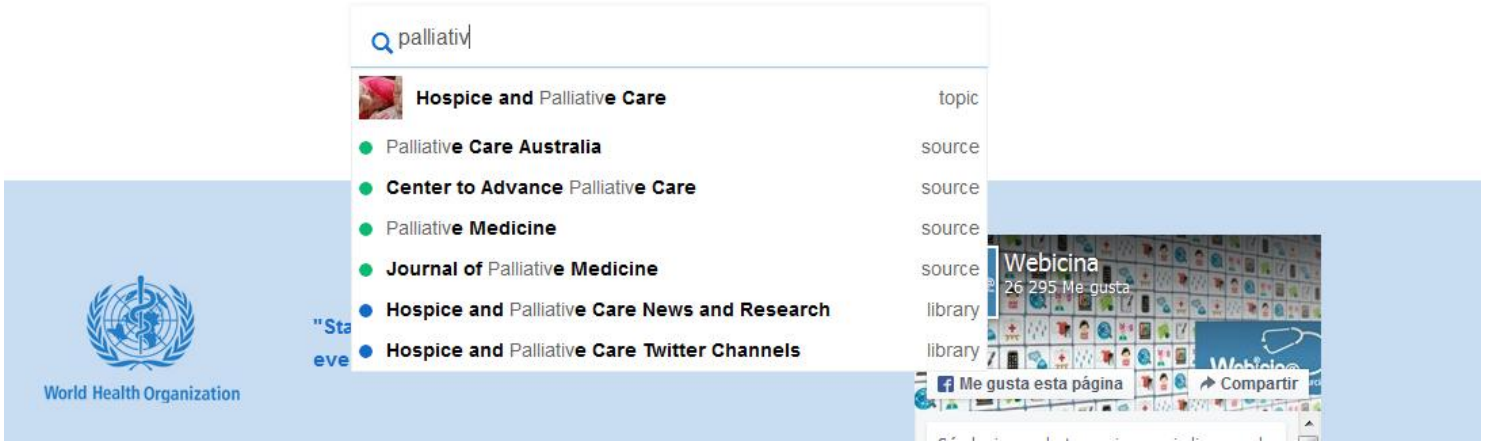

http://www.webicina.com/

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Webinars / Webinarios

- Neologismo de fusión de las palabras Web y Seminario
- Reuniones **interactivas** no presenciales
- Pueden incluir video, presentaciones, chat instantáneo, adición de otras plataformas colaborativas
- eDebates SEOM

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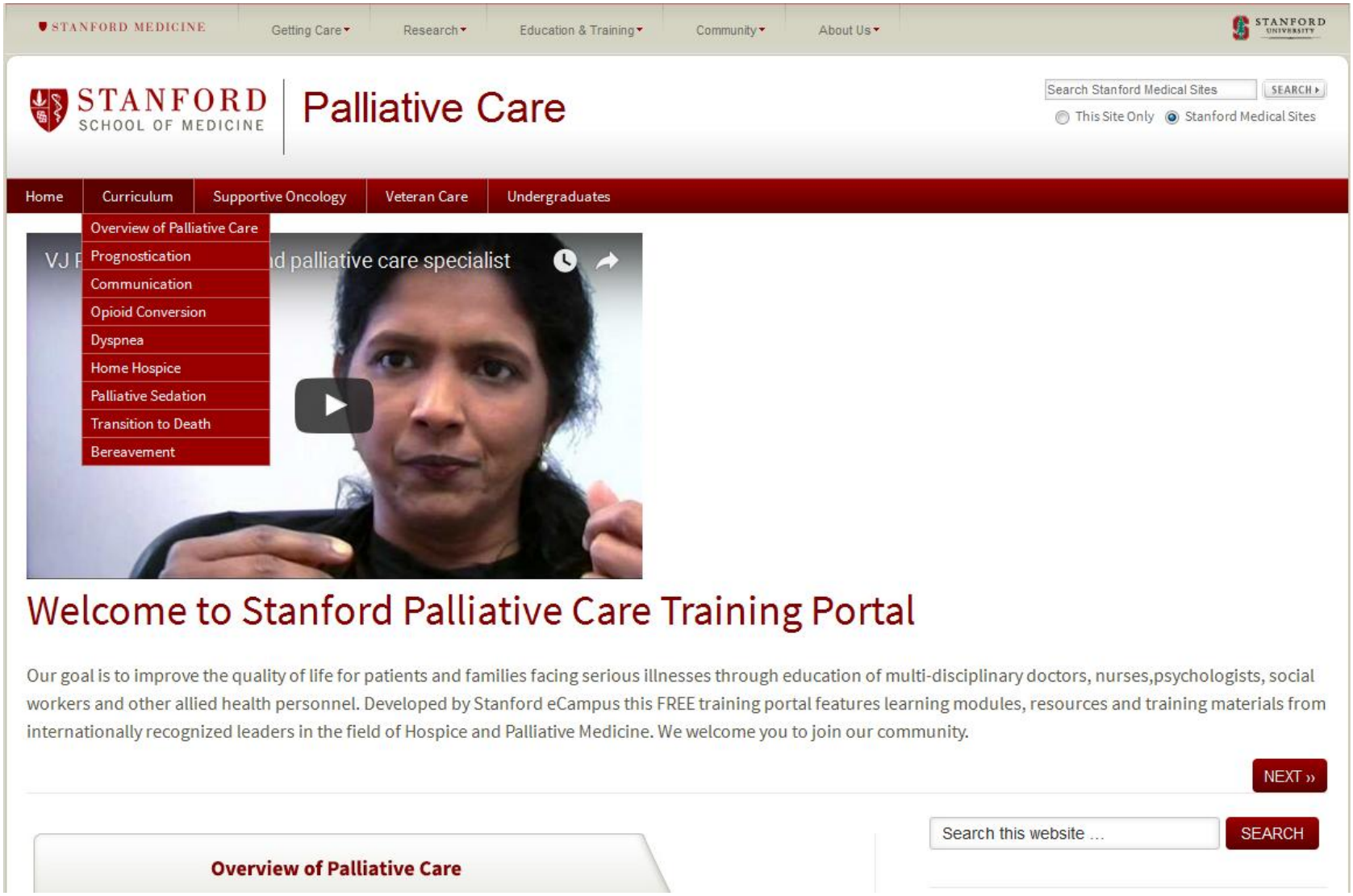
Curso Online: Stanford



http://palliative.stanford.edu/#

Equianalgesic Doses

Equianalgesic dose calculation guidelines

Case	Jack Smith is a terminally ill lung cancer patient. Jack Smith's current pain medication is oxycontin 40mg q 8 hours. Please convert it into an equianalgesic dose of parenteral hydromorphone.
Step 1	First determine total 24 hour dose of current drug. The total dose is the product of the unit dose in milligrams and the frequency of administration.

Current unit dose	= 40 milligrams
Current frequency	= 3 (pt gets the drug every eight hours which is 3 times in 24 hours)
24 hour total dose of oxycodone	= Unit dose in milligrams x Frequency
Current 24 hour total dose of oxycodone	= 40mg x 3 = 120mg

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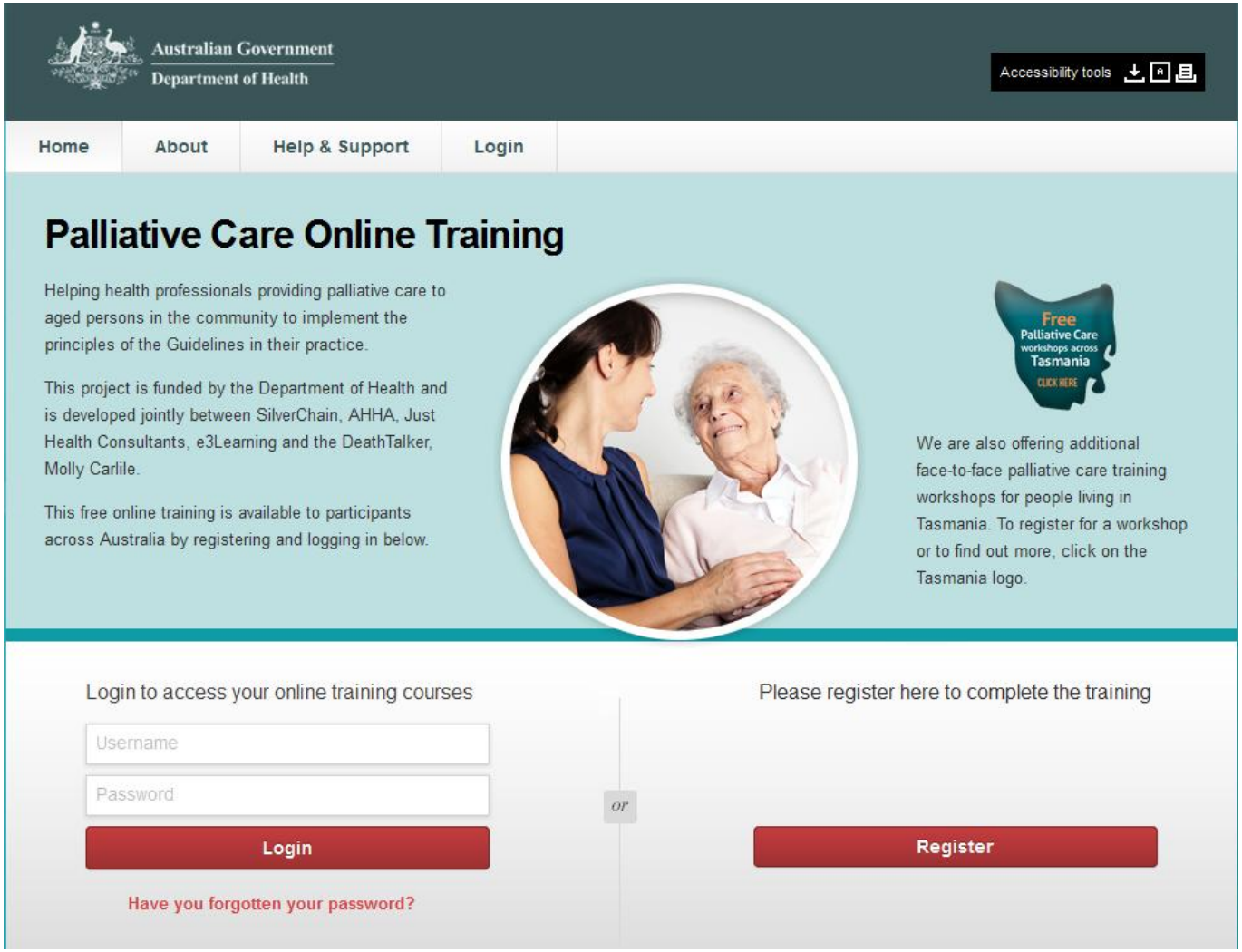

Curso Online: Yale School of Medicine

Yale SCHOOL OF MEDICINE

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Online Learning

Yale Interdisciplinary Palliative Care Educational Program is a blended curriculum with interactive computer based clinical cases which students will complete prior to participating in face to face faculty led workshops. The online curriculum must be completed prior to attending the workshop. This program is mandatory for medical students when assigned during the corresponding clerkships.

Module One:Pain and Symptom Management (Med I)

Medical Students during their third year Internal Medicine II Clerkship will participate in this online learning program which is followed by a faculty led workshop. Students must complete the online material prior to the workshop. There is a 10 question quiz at the end of the module. Students should print their quiz results and bring to the workshop for discussion.

This resource was written by Matthew Ellman, MD, Lawrence Solomon, MD, and Susan Larkin. Additional material used with permission by David E. Weissman, MD, Drew Rosielle, MD, Kathy Biernat, MS and Judi Rehm for EPERC, End of Life/Palliative Education Resource Center, © Medical College of Wisconsin, 2007 and Curriculum Emanuel LL, von Gunten CF, Ferris FD, eds. The Education in Palliative and End-of-life Care (EPEC) Curriculum: © The EPEC Project, 1999, 2003.

Module Two:Spiritual, and Cultural Aspects of Palliative Care and The Interdisciplinary Team(Med II)

Medical Students during their third year Internal Medicine II Clerkship, as well as selected Nursing, Divinity, and Social Work students or interns, will participate in this online blended learning program. There will be a workshop led by faculty from each discipline for all to attend after the online curriculum is completed.

This resource was written by Matthew Ellman, MD, Rev. Margaret Lewis, M.Div, Leslie Blatt, APRN, BC-PCM, Thomas Quinn, APRN, Diane Viveiros, LCSW, and Susan Larkin. Additional material used with permission by David E. Weissman, MD, Drew Rosielle, MD, Kathy Biernat, MS and Judi Rehm for EPERC, End of Life/Palliative Education Resource Center, © Medical College of Wisconsin, 2007 and Curriculum Emanuel LL, von Gunten CF, Ferris FD, eds. The Education in Palliative and End-of-life Care (EPEC) Curriculum: © The EPEC Project, 1999, 2003.

Module Three:
Palliative Care in the Emergency Department (Emergency Medicine Clerkship)

Medical Students during their third year Emergency Department Clerkship will participate in this online learning program.

http://palliativecare.yale.edu/

Curso Online: Yale School of Medicine

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Palliative Care Module 1

Pain Assessment and Management

Video Introduction

The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care is both a philosophy of care and an organized, highly structured system for delivering care.

Yale School of Medicine

Palliative Care Module 1

Pain Assessment and Management

Case Introduction

Mr. M is a 54 year old man admitted to your service with abdominal pain, nausea, anorexia and a 15 pound loss over 3 months since diagnosis of a locally extensive and unresectable pancreatic cancer. He was treated with radiation therapy and 5-Flourouracil over ensuing 6 weeks after diagnosis. He was also begun on MS Contin 60 mg twice daily and MSIR (immediate release morphine) 30 mg orally every 4 hours as needed. He is now re-admitted to the hospital with increasing abdominal pain and nausea. He has had scant amounts of loose to watery stools during the past week. As you enter his hospital room to evaluate him, he appears agitated and red-eyed.

***Mr. M**: "I have been through all you people's recommended treatments, and I am still in pain and not getting better. I can't live like this. What is wrong with you people? Can't you get it right? I take this pill it makes me feel like crap, I take that pill and I am out of it and can't function - I can't even watch T.V. for crying out loud! Nothing helps my pain, and it keeps getting worse. I am nauseous all the time, I can't eat, sleep, I can't do anything! And now here I am - what are you going to do to me now!"*

Yale School of Medicine

Palliative Care Module 1

Pain Assessment and Management

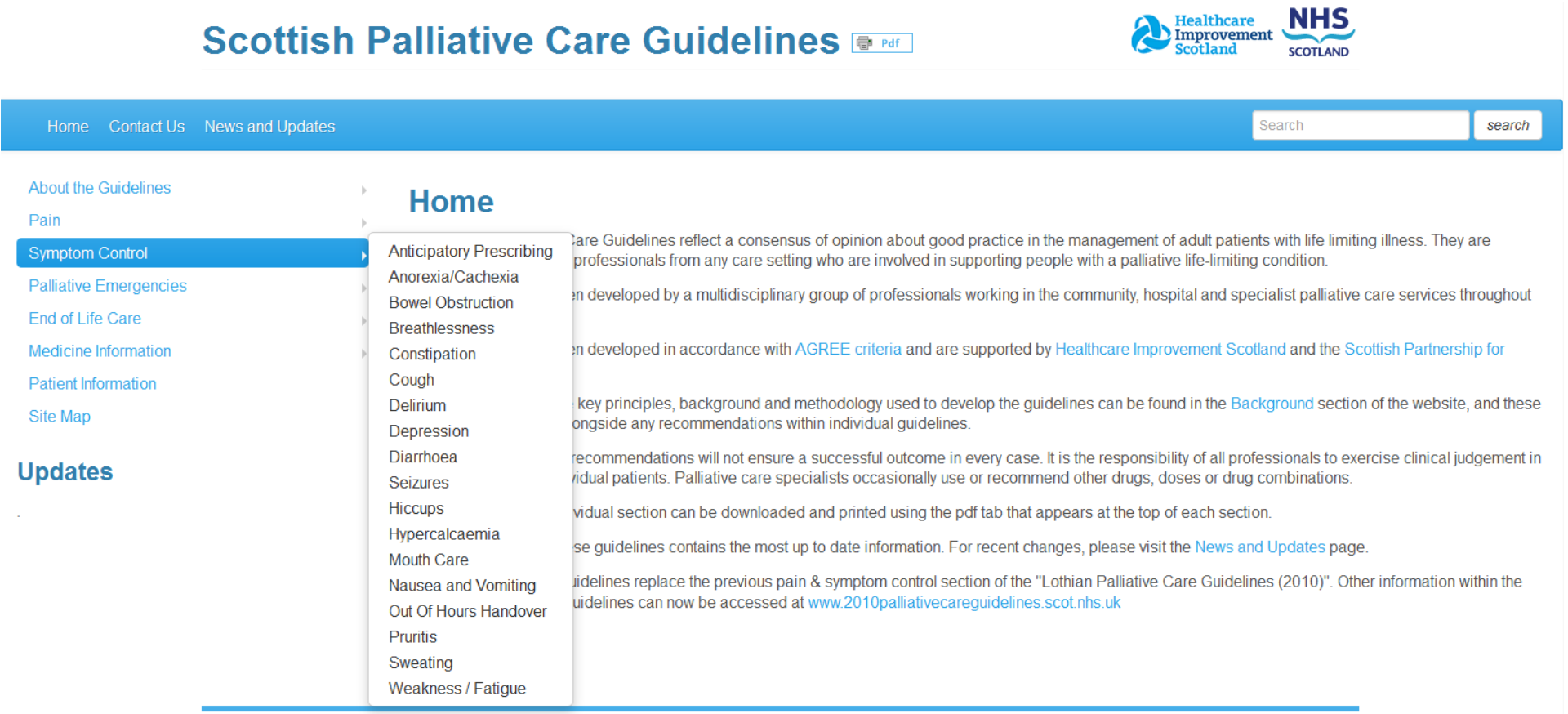
The Case: Mr. M

Based on this information, from the list below, pick and prioritize 3 issues you will evaluate and try to treat promptly:

- [ ] Agitation/Anger
- [ ] Stage of pancreatic cancer and treatment options
- [ ] Pain
- [ ] Anorexia/weight loss
- [ ] Loose stool
- [ ] Nausea

Guías Online

Guías Online: NHS Scotland



http://www.palliativecareguidelines.scot.nhs.uk/

Guías Online: NHS Scotland

Palliative Care Guidelines

NHS SCOTLAND

- Home
- Symptom Control
  - Anorexia
  - Bowel obstruction
  - Breathlessness
  - Constipation
  - Cough
  - Delirium
  - Depression
  - Emergencies
  - Fatigue
  - Hiccup
  - Itch
  - Last days of life
  - Mouth care
  - Nausea and vomiting
  - Subcutaneous fluids
  - Sweating
- Pain Management
- Subcutaneous Medication
- Medication issues
- Non-Cancer palliative care
- Care planning
- Other Issues
- Patient Information

Palliative Care Guidelines - Symptom Control - Bowel Obstruction

Introduction

- Due to mechanical obstruction of the bowel lumen and/or peristaltic failure
- Can be complex to manage - seek specialist advice
- Medical management if surgery is not appropriate consists of: -
  - general care (mouth care, fluid balance)
  - symptom control (nausea, vomiting, pain and/or colic)
- Most patients need subcutaneous medication as oral absorption is unreliable
- Review treatment regularly; symptoms often change and can resolve spontaneously

Related Guidelines:

- Nausea/vomiting
- Mouth care
- Constipation
- Subcutaneous Medication
- Subcutaneous fluids
- Fentanyl patches
- Patient leaflet: Managing nausea/vomiting

Web Resources:

- Palliative Care drug information online
- Advice on diet and eating: SCAN dieticians' group

Guideline:
Bowel Obstruction Guideline
Patient Leaflet
Subacute bowel obstruction patient leaflet

Guías Online: NHS Scotland

Cough

Introduction

Cough is a forced expulsive manoeuvre usually against a closed glottis, which is associated with a characteristic sound. It usually has a protective function in maintaining patency and cleanliness of the airways.

The impact of cough on patients and relatives is often underestimated. Patients may need symptomatic treatment when cough is persistent, distressing or affecting sleep and/or quality of life. An assessment of the pattern and character of the patient's cough is essential to optimise treatment. Acute cough is defined as duration of <3 weeks, subacute as 3 to 8 weeks, chronic as >8 weeks. For information on the nature of cough, see the Management section.

Assessment

- Ask the patient to rate cough frequency, severity and level of associated distress or anxiety.
- Explore:
  - understanding of the reasons for cough
  - fears (including fear of choking)
  - impact on:
    - functional abilities (including continence)
    - quality of life
    - families and carers.
- Clarify:
  - pattern, character and duration of cough
  - precipitating/alleviating factors for cough
  - associated symptoms
  - occupational history.
- Look for any potentially reversible causes of cough, such as:
  - infection
  - pleural or pericardial effusion
  - pulmonary embolism
  - gastro-oesophageal reflux
  - bronchospasm.
- Determine if treatment of the underlying disease is appropriate. Seek advice if in doubt.
- Assess character of sputum and consider sputum culture if necessary. See table 3.
- Consider chest X-ray.

Issue Date: 31/05/2014

Review Date: 31/05/2017

Management[1]

- If stridor is present, seek specialist advice. Give high-dose steroids in divided doses:
  - †dexamethasone 16mg orally or subcutaneously, or prednisolone 60mg orally. Consider gastric protection.
- Consider treating any potentially reversible causes.
- Optimise current therapy (non-drug management and medication); in particular, ensure adequate analgesia as pain may inhibit effective coughing.
- Acknowledge fear and anxieties, and provide supportive care. Offer written information and verbal explanation.
- Consider referral to physiotherapy services if difficulty in expectorating retained secretions.
- Agree a self-management plan which could include:
  - cough diary
  - smoking cessation advice.
  - improved ventilation such as opening a window, putting on a fan
  - coping strategies, such as:
    - positioning and posture
    - relaxation
    - controlled breathing technique and effective coughing techniques, eg huffing.
- Seek specialist advice for the small number of patients who may require suction or a cough assist machine.

Specific advice on managing a dry (non-productive) cough

A persistent refractory cough may prompt the initial diagnosis of a primary lung malignancy or pulmonary metastases and specific chemotherapy/radiotherapy may be appropriate, depending on histology and fitness.

Post-radiotherapy lung damage, pneumonitis and lymphangitis (which can be associated with breathlessness and cyanosis) may respond to steroid therapy. Seek oncology advice.

† Indicates this use is off license
Indicates this medication is associated with QT prolongation

Issue Date: 31/05/2014

Review Date: 31/05/2017

Table 1 Management of a dry (non-productive) cough

Nature of cough	Possible cause	Potential treatment
Onset related to the commencement of medication	Angiotensin-converting-enzyme (ACE) inhibitors	Discontinue or switch to alternative medication
Rapid onset of cough, associated with dyspnoea	Pleural effusion	Consider pleural drainage and pleurodesis
	Pericardial effusion	Consider pericardiocentesis and pericardiosclerosis
	Pulmonary embolism (usually dry cough but may have haemoptysis)	Consider merits of anticoagulation with low molecular weight heparin (LMWH)
Barking cough (short duration)	Pharyngitis/tracheobronchitis/ early pneumonia	Consider antibiotics, humidify room air
Harsh croup (coarse)	Laryngitis	Humidify room air, advise resting of voice
Bovine cough	Recurrent laryngeal nerve palsy (from intrathoracic compression or disease)	Consider referral to ear, nose and throat (ENT) for possible vocal cord injection
Hard brassy cough (with or without wheeze or stridor)	Tracheal compression from thoracic lesions or nodes, superior vena cava obstruction (SVCO)	Consider radiotherapy, steroids, stenting (see SVCO section in the Breathlessness guideline)
Wheezy cough	Airflow obstruction (asthma, chronic obstructive pulmonary disease (COPD))	Optimise inhaled therapy, consider steroids

Cough Table 1. Version 1 May 2014

Medication
In addition to the advice described in Table 1, consider treatment to suppress a dry cough:

- simple linctus
- ±morphine (monitor for side effects including opioid toxicity)
  - opioid naive – 2mg orally, 4 to 6 hourly if required (6 to 8 hourly if frail or elderly)
  - already on morphine – continue and use the existing immediate-release breakthrough analgesic dose (oral if able or subcutaneous equivalent) for the relief of cough. A maximum of 6 doses can be taken in 24 hours for all indications (pain, breathlessness and cough). Titrate both regular and breakthrough doses as required.
- Specialist referral if symptoms persist for consideration of other treatments.

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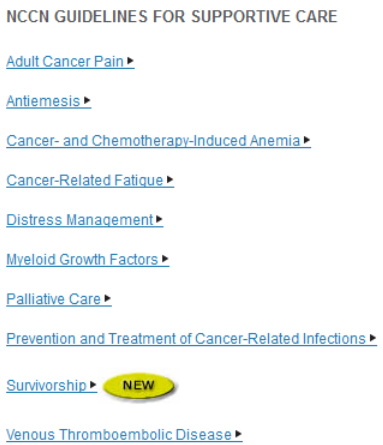
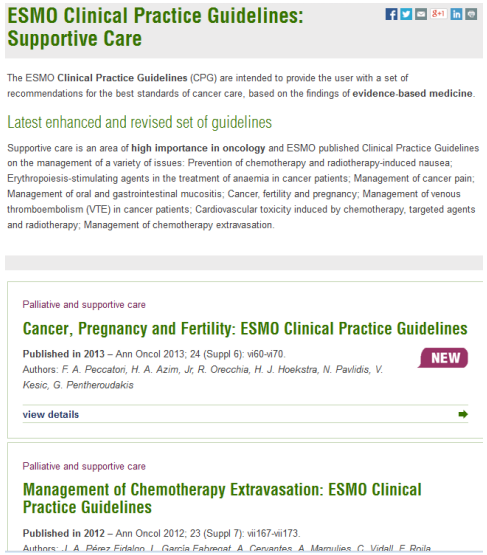
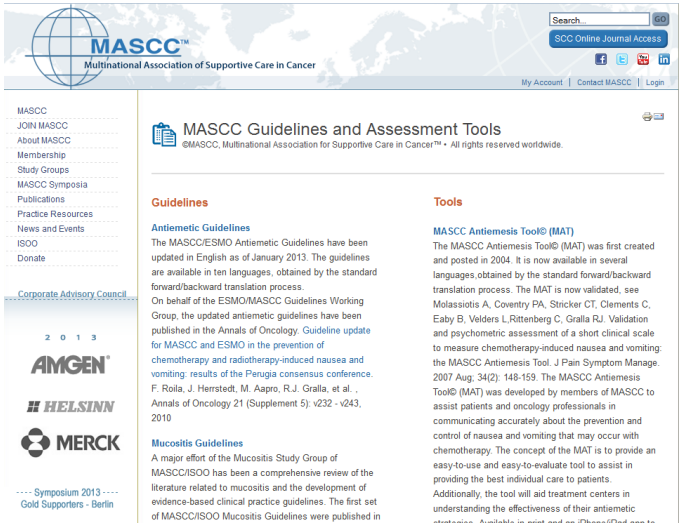
Guias online: Otras guias





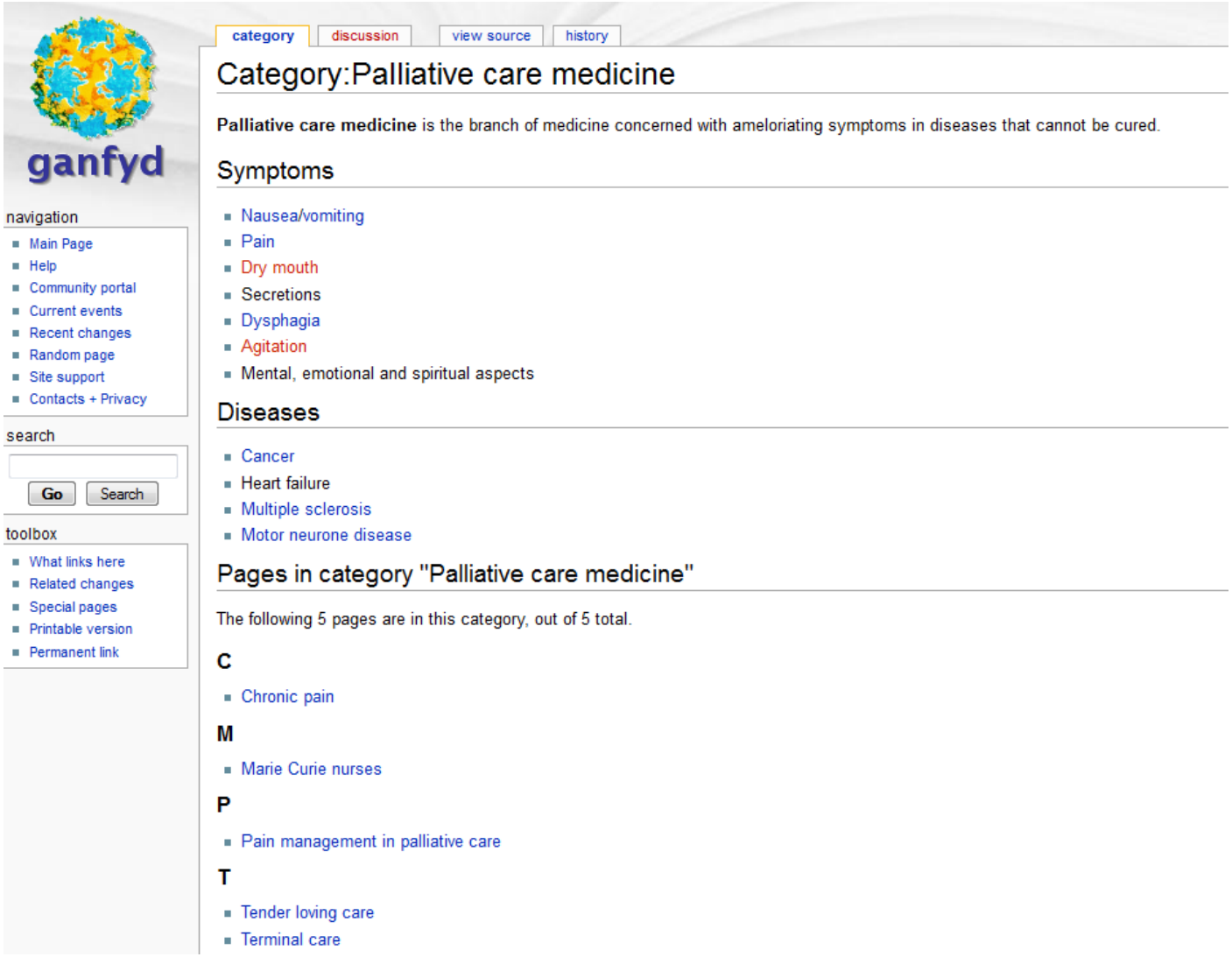


Wikis

Wikis

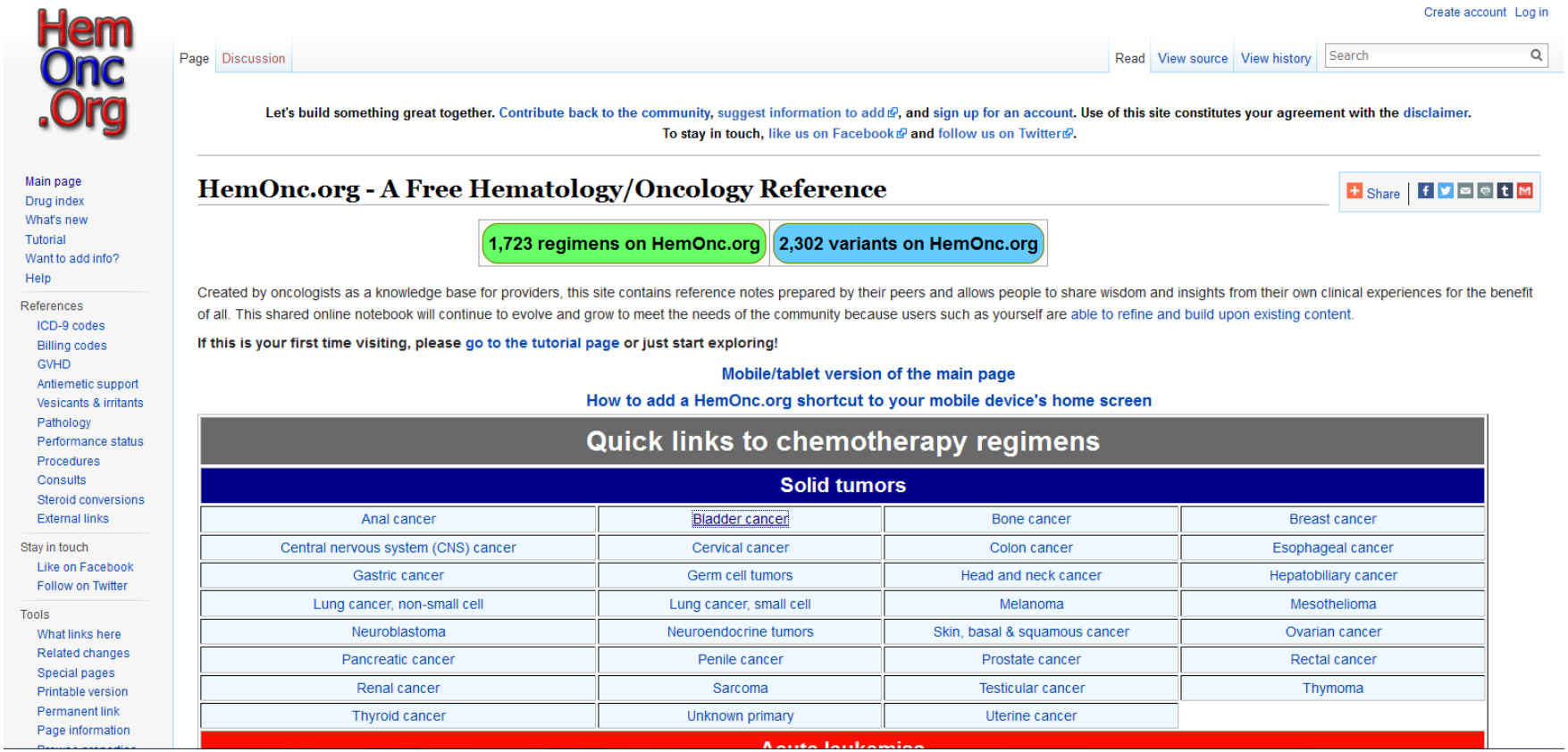
- Sitio web cuyas páginas pueden ser editadas por múltiples voluntarios a través del navegador web
- Del Hawaiano “wiki” que significa rapido
- Existen algunos profesionalizados en que solo pueden escribir profesionales acreditados
- Se puede buscar información en varios a la vez a través de MetaWiki

Wikis: ganfyd



http://www.ganfyd.org/index.php?title=Main_Page

Wikis: HemOnc



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HemOnc.org - A Free Hematology/Oncology Reference

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Created by oncologists as a knowledge base for providers, this site contains reference notes prepared by their peers and allows people to share wisdom and insights from their own clinical experiences for the benefit of all. This shared online notebook will continue to evolve and grow to meet the needs of the community because users such as yourself are able to refine and build upon existing content.

If this is your first time visiting, please go to the tutorial page or just start exploring!

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How to add a HemOnc.org shortcut to your mobile device's home screen

Quick links to chemotherapy regimens

Solid tumors

Anal cancer	Bladder cancer	Bone cancer	Breast cancer
Central nervous system (CNS) cancer	Cervical cancer	Colon cancer	Esophageal cancer
Gastric cancer	Germ cell tumors	Head and neck cancer	Hepatobiliary cancer
Lung cancer, non-small cell	Lung cancer, small cell	Melanoma	Mesothelioma
Neuroblastoma	Neuroendocrine tumors	Skin, basal & squamous cancer	Ovarian cancer
Pancreatic cancer	Penile cancer	Prostate cancer	Rectal cancer
Renal cancer	Sarcoma	Testicular cancer	Thymoma
Thyroid cancer	Unknown primary	Uterine cancer	

Acute leukemias

http://hemonc.org/wiki/Main_Page

Wikis: Wikipedia

Sedación terminal

La **sedación terminal** es un procedimiento médico para el que conceptualmente aún no existe una definición unívoca y que se continúa discutiendo de manera controversial. En lo esencial se trata de la administración de medicamentos con un fuerte efecto tranquilizante y sedante a una persona que está al borde de la muerte. Debido a que en principio existe la posibilidad de acelerar el deceso del paciente a través de una medida de este tipo, el límite entre la sedación terminal y la eutanasia es difuso y controvertido. Por esta razón, muchos médicos prefieren utilizar el concepto de **sedación paliativa**. Además, en el caso de algunas asociacones médicas, se considera a las prácticas de sedación terminal como un subconjunto o un tipo particular de la sedación paliativa que se aplica en la fase de agonía.

Índice [ocultar]

En la medicina paliativa [editar · editar código]

Los profesionales especializados en medicina paliativa entienden bajo el concepto de sedación terminal la administración de medicamentos que reducen el nivel de consciencia del paciente moribundo, o incluso se la desactivan completamente, con el objetivo de aliviar sus síntomas más agobiantes, tales como el dolor, la angustia o el miedo en la última fase vital. Así, esta sedación — que debería servir de manera unívoca a la vida y no a la muerte — lograría que el tiempo que resta hasta la muerte se viva de un modo más aceptable y soportable.

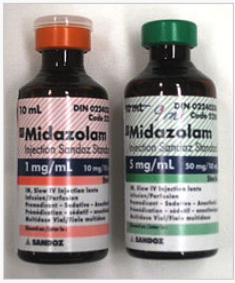
De acuerdo con esta definición, el control del síntoma sería la única meta de la sedación terminal. En esta misma línea, el anestesista y médico berlinés, Hans-Christof Müller-Busch, especialista en medicina paliativa, ha publicado en (2004) en la *Zeitschrift für Palliativmedizin* (Revista de Medicina Paliativa) estudios tendientes a demostrar que los pacientes bajo sedación terminal no morirían más rápidamente que aquellos que no reciben estos medicamentos con fuerte efecto tranquilizante y analgésico. El investigador informa que, por ejemplo, dos tercios de sus propios pacientes bajo sedación terminal en las últimas horas de vida estuvieron en condiciones de ingerir líquidos y que un 13% incluso pudo consumir alimentos sólidos.

En la medicina paliativa, la sedación terminal se considera un componente obvio y natural del control de síntomas; un procedimiento que de acuerdo con los estándares actuales no conduciría al acortamiento de la vida y que por tanto se la ha situado de manera injusta como una práctica aledaña a la eutanasia o a las medidas tendiendes a dar muerte a los pacientes de modo ilegal.

Un grupo internacional de expertos elaboró y publicó directrices para la indicación y procedimiento de la sedación paliativa. En el informa final que elaboraron se discuten los aspectos más críticos de este concepto: ¿se emplea la sedación terminal realmente solo como última posibilidad en el alivio de los síntomas? ¿es lícito que sea utilice también en el caso de carga psicosocial («sufrimiento vital»)? ¿está permitido aplicarla solo al final de la vida o puede usarse también antes, en el transcurso de las enfermedades graves? Tal como muestran las investigaciones Müller-Busch, con el incremento de esta práctica se ha elevado la fracción de sedaciones terminales debidas a causas psicosociales.[1]

Por su parte, la Sociedad Española de Cuidados Paliativos ha elaborado algunas directrices, definiciones y consideraciones éticas. Allí se ha preferido distinguir claramente los conceptos de

Sedación terminal



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Impact of Hospice Payment Reform on Meeting Psychosocial Needs of Family at End of Life

by Debbie Parker-Oliver

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Hospice payment reform has arrived. A recent study by Joan Teno and Michael Plotzke presented to CMS found an alarming number of patients were not getting hospice visits in the final days of life. Likewise, a recent study out of the University of Buffalo looked at the experiences of EMTs handling death and dying calls, many of which were with hospice patients. Both of these studies cause us to wonder where the hospice staff visits were during these very difficult days/hours. Why didn't family call them rather...

Monday, January 11, 2016 by Pallimed Editor ·

Looking Ahead at 2016 for Palliative Care

by Christian Sinclair 2015 was a pretty exciting year in palliative care, but 2016 has a lot happening as well. Here are some of the things to put on your calendar right now, so you do not miss them! To access these dates via Google Calendar (HTML), click here. To import a .ics file of all current dates to your calendar software, click...

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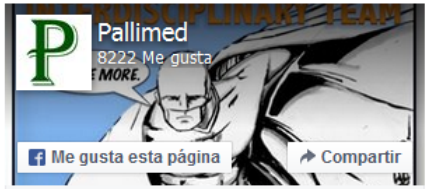

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Podcast: Hospice of the Bluegrass

Issues in End of Life Care

PODCAST 03-20-2015 *(9.76 MB)*

Duration: 10:40 m - Filetype: mp3 - Bitrate: 128 KBPS - Frequency: 44100 HZ

National Social Work Month: A Conversation with Lindsay Kampfer

- Hospice of the Bluegrass social worker Lindsay Kampfer discusses the work of social workers in the context of end-of-life care.

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PODCAST 03-04-2015 *(24.35 MB)*

Duration: 26:36 m - Filetype: mp3 - Bitrate: 128 KBPS - Frequency: 44100 HZ

A higher quality end-of-life conversation

- Dr. Allison Scott from the University of Kentucky describes her recent research and provides insight on how families can have high quality conversations about goals, preferences and values for medical care at end-of-life

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PODCAST 04-28-2014 *(32.48 MB)*

Duration: 35:28 m - Filetype: mp3 - Bitrate: 128 KBPS - Frequency: 44100 HZ

A Discussion of Hospice Eligibility and Recertification

- Dr. Salli Whisman discusses current issues related to hospice eligibility and recertification with Turner West.

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PODCAST 04-03-2014 *(54.74 MB)*

http://www.hospicebg.org/podcast/

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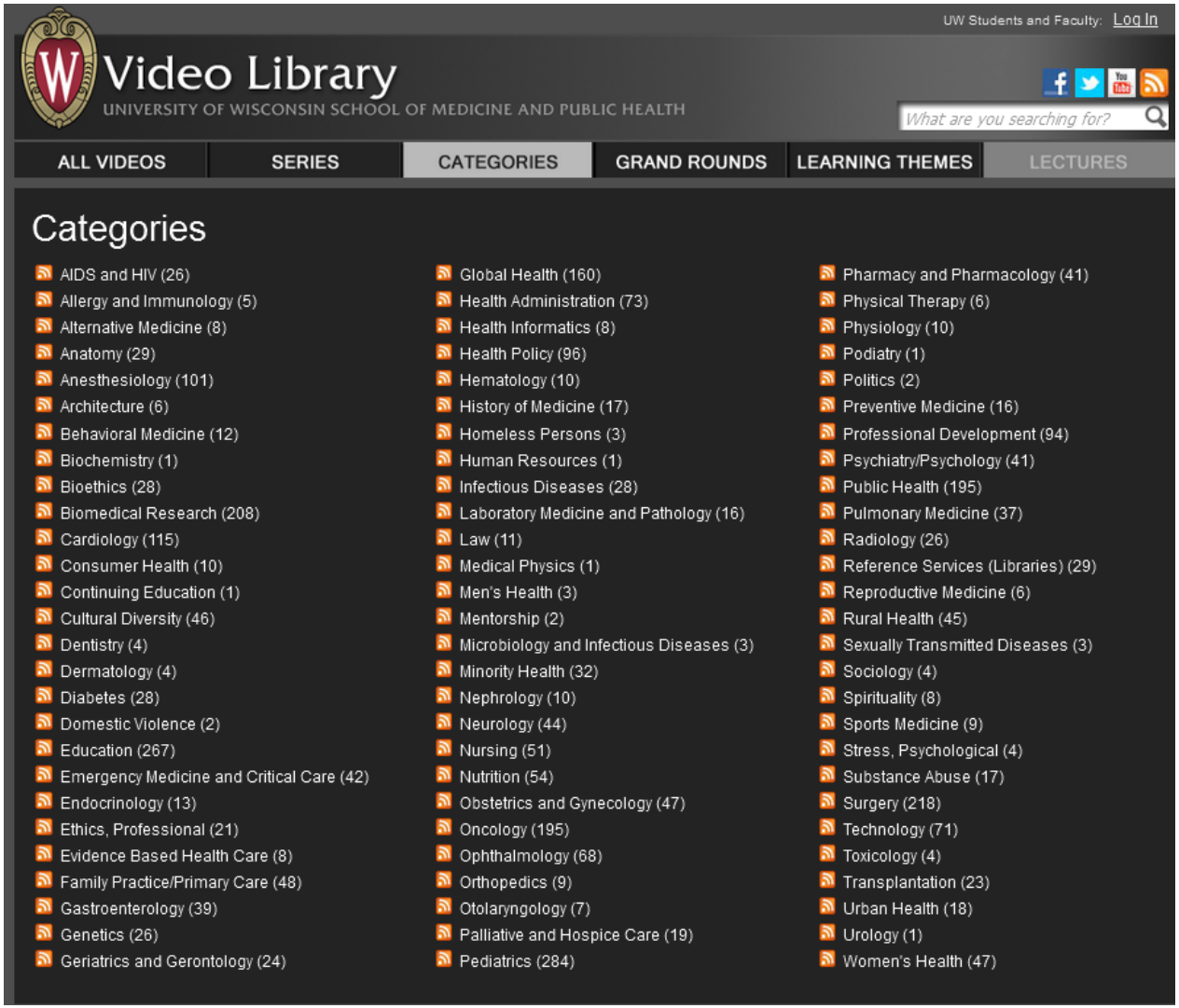

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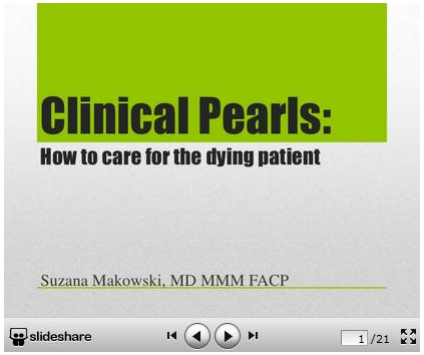

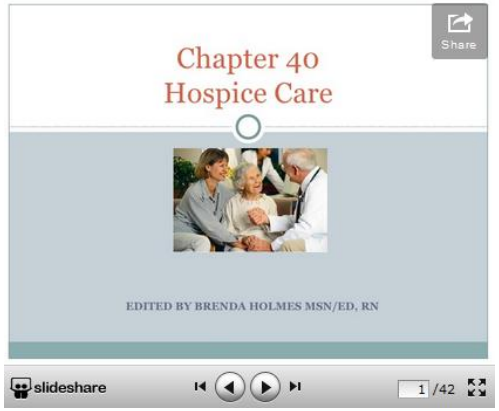

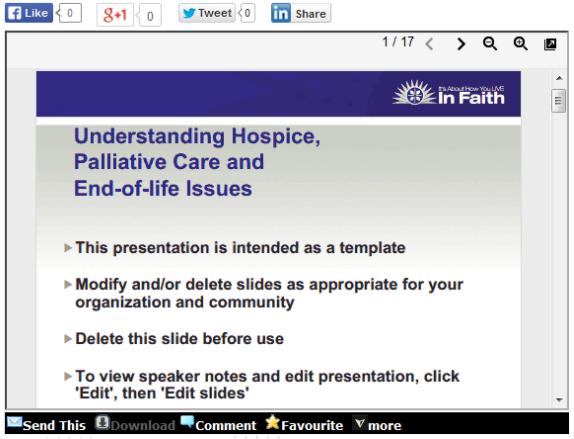

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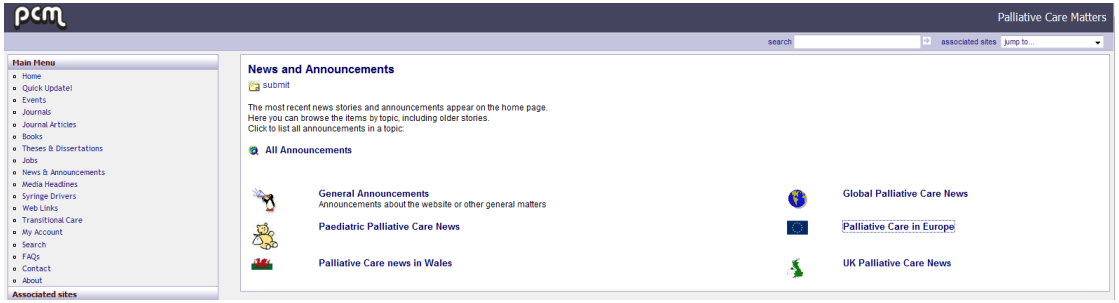

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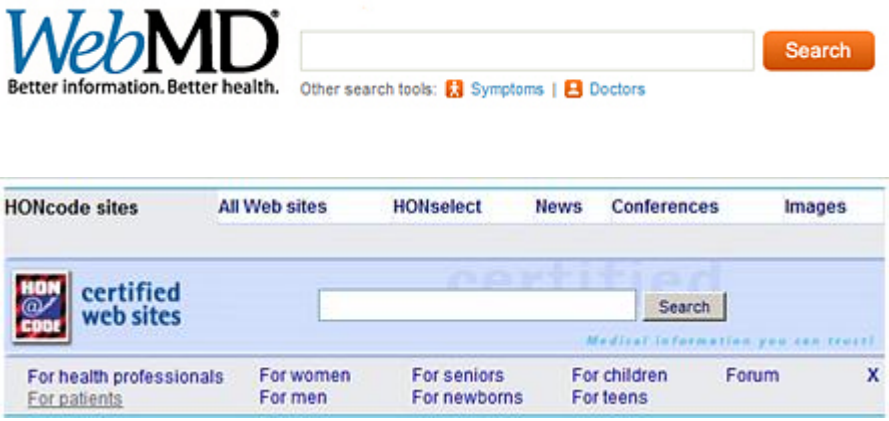
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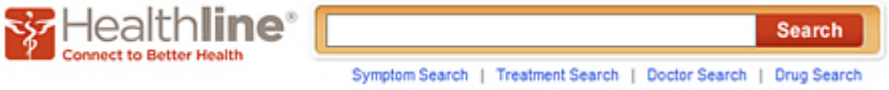
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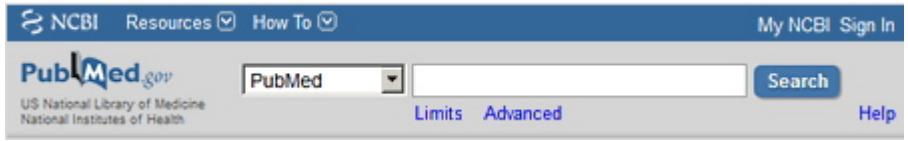
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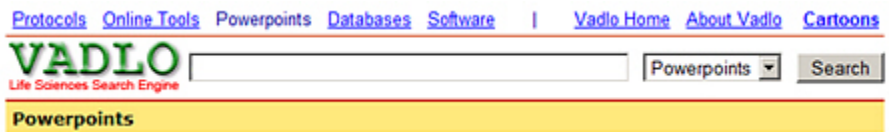
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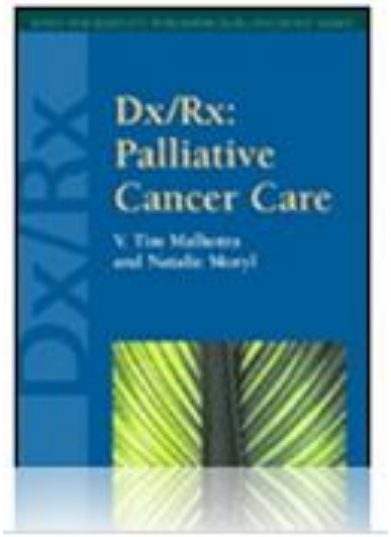

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A Quick-Reference Guide to the Hospice and Palliative Care Training For Physicians

For practicing physicians and clinicians who work with patients with advanced disease.

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Covering the latest in research and news for the field. The target audience is health care professionals, but the tone is conversational so anyone can join in.

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Dx/Rx: Palliative Cancer Care

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