

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

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Hospital General Universitario Valencia

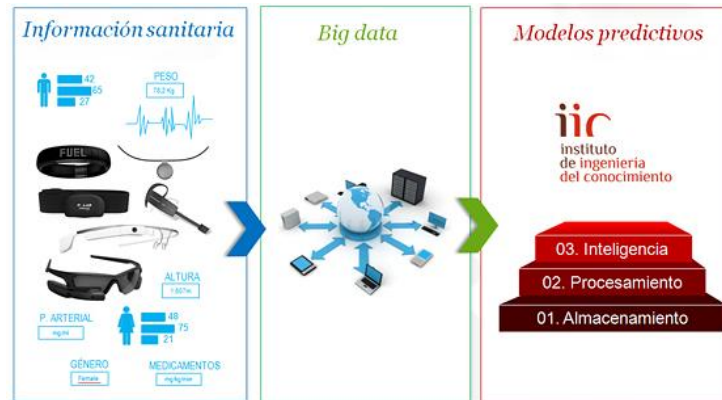
La información

- 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
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CancerLinQ™

The ASCO Institute for Quality, LLC, is leading the development of CancerLinQ™, a cutting-edge health information technology (HIT) platform that will revolutionize how we care for people with cancer. By enabling us to learn from each of the millions of individual patients living with cancer nationwide, CancerLinQ will improve the quality and value of cancer care for all.

CancerLinQ's development is well under way. Once complete, CancerLinQ will aggregate and analyze a massive web of real-world cancer care data in order to:

- **Provide real-time quality feedback to providers:** CancerLinQ will enable oncology practices to measure how their care compares against guidelines and compares to their peers based on aggregated reports of quality, offering instant feedback and guidance for improvement.
- **Feed personalized insights to doctors:** CancerLinQ's real-time clinical decision support will help physicians choose the right therapy at the right time for each patient, based on clinical guidelines and the experiences of many similar patients.
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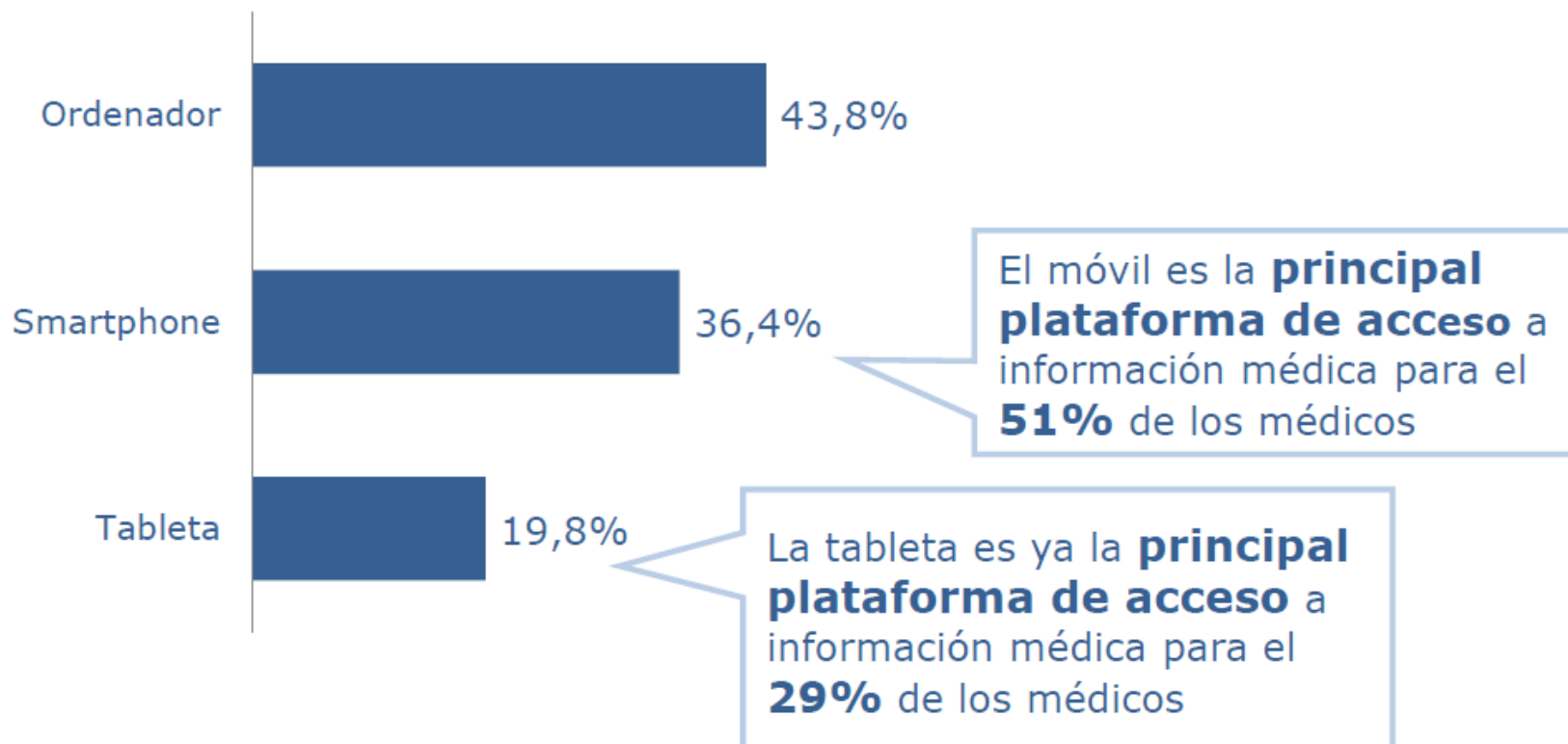
- Los nuevos alumnos son “nativos digitales”
 - Han crecido en un mundo de información digital
- Los docentes son “colonos digitales”
 - No son “digitales de nacimiento”
 - En la actualidad “viven en digital”

Los nuevos docentes

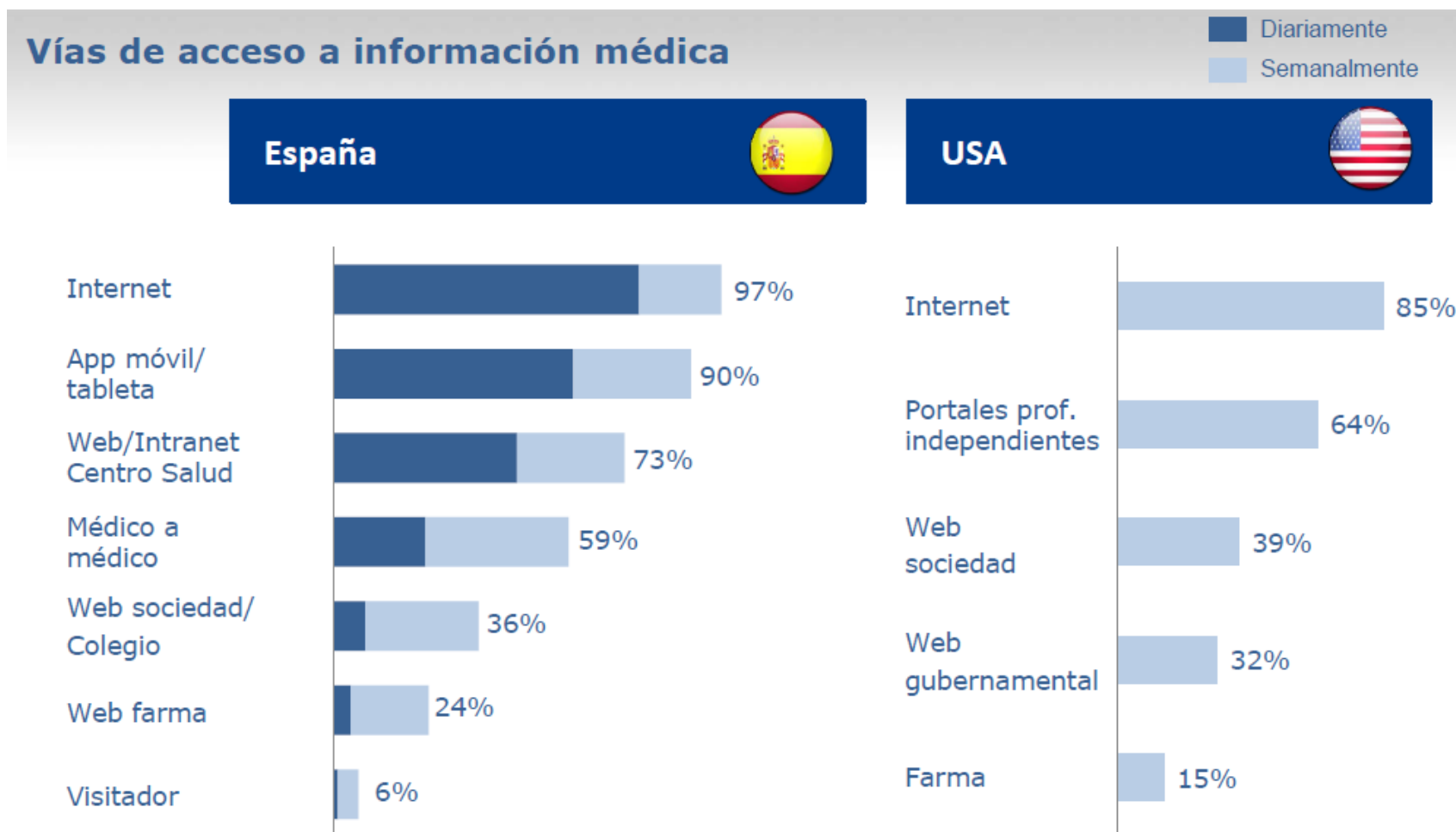
- Deben incorporar nuevas tecnologías sin reemplazar la comunicación cara a cara, deben dar soporte.
- Deben establecer objetivos docentes y no dejar todo a las tecnologías
- Se debe facilitar amplia variedad de material
- Deben apoyar el desarrollo de tecnologías educativas

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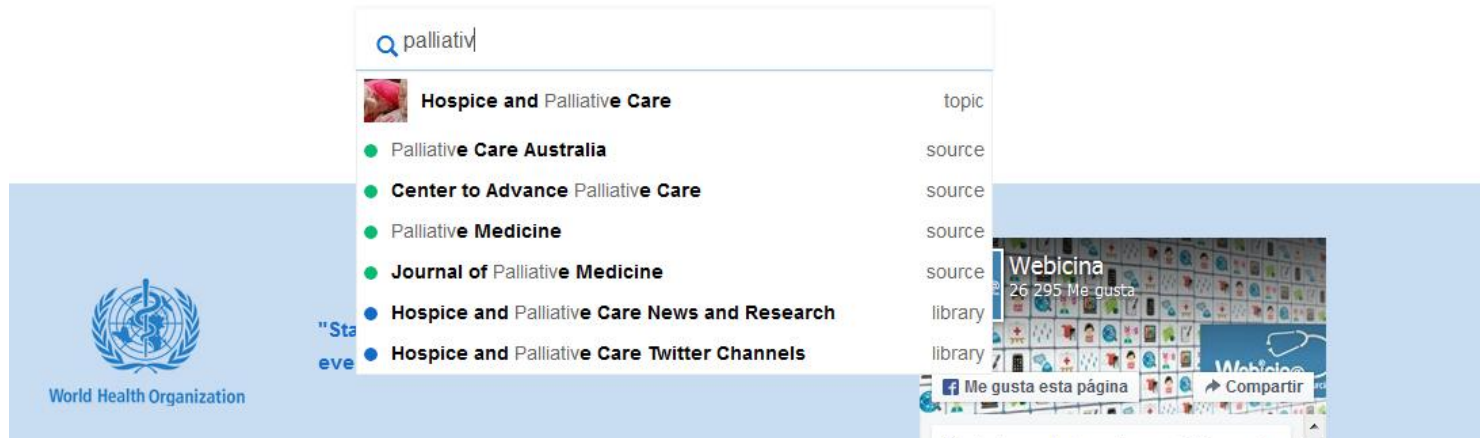
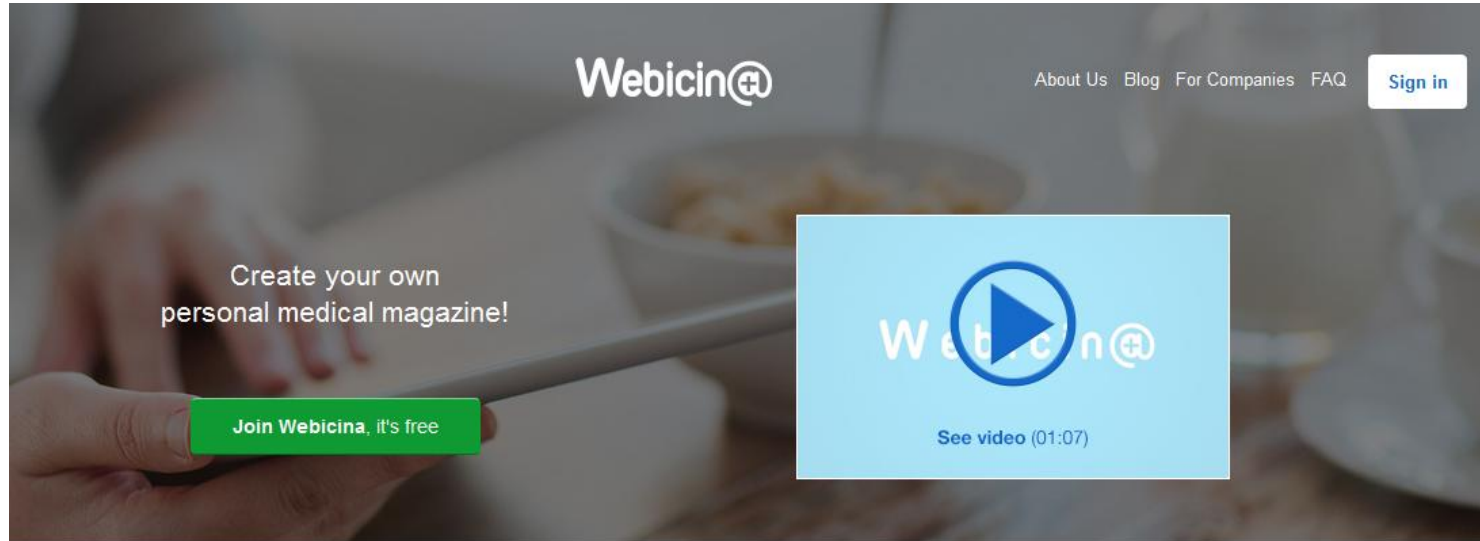
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- Neologismo de fusión de las palabras Web y Seminario
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VJ P

and palliative care specialist

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Our goal is to improve the quality of life for patients and families facing serious illnesses through education of multi-disciplinary doctors, nurses, psychologists, social workers and other allied health personnel. Developed by Stanford eCampus this FREE training portal features learning modules, resources and training materials from internationally recognized leaders in the field of Hospice and Palliative Medicine. We welcome you to join our community.

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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

Opioid Conversion

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- » [Opioids](#)
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- » [Equianalgesic Doses](#)
- » [Land Mines](#)
- » [Teaching Exercise 1:](#)
 - » [Converting from oral to parenteral morphine](#)
 - » [The Case Continues](#)
- » [Teaching Exercise 2:](#)
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IX Curso SEOM para Residentes de Manejo de Síntomas y Terapia de Soporte en el Paciente Oncológico



2014 VALENCIA
16 y 17 de enero

Ayre Hotel Astoria Palace Plaza de Rodrigo Boscá nº5

IX CURSO SEOM
para RESIDENTES de MANEJO de
SÍNTOMAS y TERAPIA de SOPORTE en el
PACIENTE ONCOLÓGICO

Fecha: 16 y 17 de enero de 2014

Lugar: Valencia

Presidente: Dra. Pilar Garrido

Coordinadores Científicos:

Teléfono: 91 577 52 81

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Curso Online: Palliative Care Online



Australian Government
Department of Health

Accessibility tools   



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Palliative Care Online Training

Helping health professionals providing palliative care to aged persons in the community to implement the principles of the Guidelines in their practice.

This project is funded by the Department of Health and is developed jointly between SilverChain, AHHA, Just Health Consultants, e3Learning and the DeathTalker, Molly Carlile.

This free online training is available to participants across Australia by registering and logging in below.



We are also offering additional face-to-face palliative care training workshops for people living in Tasmania. To register for a workshop or to find out more, click on the Tasmania logo.

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Palliative and End-of-Life Care Education

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Fax: 203.737.4875
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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. Students should print their "reflection" (formatted in text box at the end of the on-line module) and bring it to their attending

Curso Online: Yale School of Medicine

Yale School of Medicine

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-Fluorouracil 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

Scottish Palliative Care Guidelines Pdf



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- Hiccups
- Hypercalcaemia
- Mouth Care
- Nausea and Vomiting
- Out Of Hours Handover
- Pruritis
- Sweating
- Weakness / Fatigue

Palliative Care Guidelines reflect a consensus of opinion about good practice in the management of adult patients with life limiting illness. They are developed by a multidisciplinary group of professionals working in the community, hospital and specialist palliative care services throughout Scotland. The guidelines were developed in accordance with [AGREE criteria](#) and are supported by [Healthcare Improvement Scotland](#) and the [Scottish Partnership for Palliative Care](#). The key principles, background and methodology used to develop the guidelines can be found in the [Background](#) section of the website, and these are alongside any recommendations within individual guidelines. The recommendations will not ensure a successful outcome in every case. It is the responsibility of all professionals to exercise clinical judgement in the management of individual patients. Palliative care specialists occasionally use or recommend other drugs, doses or drug combinations. Each individual section can be downloaded and printed using the pdf tab that appears at the top of each section. This website contains the most up to date information. For recent changes, please visit the [News and Updates](#) page. These guidelines replace the previous pain & symptom control section of the "Lothian Palliative Care Guidelines (2010)". Other information within the guidelines can now be accessed at www.2010palliativecareguidelines.scot.nhs.uk

Guías Online: NHS Scotland

Palliative Care Guidelines



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- Symptom Control
 - Anorexia
 - Bowel obstruction
 - Breathlessness
 - Constipation
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 - Delirium
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 - Emergencies
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 - 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.

Management¹

- If stridor is present, seek specialist advice. Give high-dose steroids in divided doses:
 - \pm 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.

¹ Indicates to be seen off box

² Indicates to be discussed with the GP/physician

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 pericardiotomy
	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)
Wheasy cough	Airflow obstruction (asthma, chronic obstructive pulmonary disease (COPD))	Optimise inhaled therapy, consider steroids

Cough Table 1, Version 3, May 2014

Medication

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

- simple linctus
- \pm morphine (monitor for side effects including opioid toxicity)
 - opioid naïve – 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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Quality & Guidelines > Guidelines > Supportive Care and Quality of Life Guidelines > ASCO Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care

ASCO Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care

Published in Journal of Clinical Oncology, Vol 30, Issue 8 (March), 2012: 890-897
Thomas J. Smith, Sarah Terima, Erin R. Alea, Amy P. Abernethy, Tracy A. Balboni, Ethan M. Basch, Betty R. Ferrel, Matt Loscalzo, Diane E. Meier, Judith A. Pace, Jeffrey M. Peppercorn, Mark Somerfield, Ellen Stoval, and Jamie H. Von Roem

Purpose: An American Society of Clinical Oncology (ASCO) provisional clinical opinion (PCO) offers timely clinical direction to ASCO's membership following publication or presentation of potentially practice-changing data from major studies. This PCO addresses the integration of palliative care services into standard oncology practice at the time a person is diagnosed with metastatic or advanced cancer.

Clinical Context: Palliative care is frequently misconstrued as synonymous with end-of-life care. Palliative care is focused on the relief of suffering, in all of its dimensions, throughout the course of a patient's illness. Although the use of hospice and other palliative care services at the end of life has increased, many patients

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ESMO Clinical Practice Guidelines: Supportive Care



The ESMO Clinical Practice Guidelines (CPG) are intended to provide the user with a set of recommendations for the best standards of cancer care, based on the findings of evidence-based medicine.

Latest enhanced and revised set of guidelines

Supportive care is an area of **high importance in oncology** and ESMO published Clinical Practice Guidelines on the management of a variety of issues. Prevention of chemotherapy and radiotherapy-induced nausea; Erythropoiesis-stimulating agents in the treatment of anaemia in cancer patients; Management of cancer pain; Management of oral and gastrointestinal mucositis; Cancer, fertility and pregnancy; Management of venous thromboembolism (VTE) in cancer patients; Cardiovascular toxicity induced by chemotherapy, targeted agents and radiotherapy; Management of chemotherapy extravasation.

Palliative and supportive care

Cancer, Pregnancy and Fertility: ESMO Clinical Practice Guidelines

Published in 2013 - Ann Oncol 2013; 24 (Suppl 6): vi60-vi70

Authors: F. A. Peccatori, H. A. Azim, Jr, R. Orecchia, H. J. Hoekstra, N. Pavlidis, V. Kasic, G. Penteroudakis

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Palliative and supportive care

Management of Chemotherapy Extravasation: ESMO Clinical Practice Guidelines

Published in 2012 - Ann Oncol 2012; 23 (Suppl 7): vi167-vi173

Authors: J. A. Pérez-Fidalgo, J. García-Fahnest, A. Cevantes, A. Mamules, C. Virdall, F. Rola

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Expert-reviewed information summary about the difficult emotional responses many cancer patients experience. This summary focuses on normal adjustment issues, psychosocial distress, and adjustment disorders.

[Cardiopulmonary Syndromes \(PDQ®\)](#)
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Expert-reviewed information summary about common conditions that produce chest symptoms. The cardiopulmonary syndromes addressed in this summary are cancer-related dyspnea, malignant pleural effusion, pericardial effusion, and superior vena cava syndrome.

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Expert-reviewed information summary about communicating with the cancer patient and his or her family, including unique aspects of communication with cancer patients, factors affecting communication, and training in communication skills.

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[Depression \(PDQ®\)](#)
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Guidelines

Antiemetic Guidelines
The MASCC/ESMO Antiemetic Guidelines have been updated in English as of January 2013. The guidelines are available in ten languages, obtained by the standard forward/backward translation process.
On behalf of the ESMO/MASCC Guidelines Working Group, the updated antiemetic guidelines have been published in the Annals of Oncology. [Guideline update for MASCC and ESMO in the prevention of chemotherapy and radiotherapy-induced nausea and vomiting: results of the Perugia consensus conference.](#) F. Rola, J. Herrstedt, M. Aapro, R.J. Gralla, et al. Annals of Oncology 21 (Supplement 5): v232 - v243, 2010

Mucositis Guidelines
A major effort of the Mucositis Study Group of MASCC/ISOO has been a comprehensive review of the literature related to mucositis and the development of evidence-based clinical practice guidelines. The first set of MASCC/ISOO Mucositis Guidelines were published in

Tools

MASCC Antiemesis Tool® (MAT)
The MASCC Antiemesis Tool® (MAT) was first created and posted in 2004. It is now available in several languages, obtained by the standard forward/backward translation process. The MAT is now validated, see Molassiotis A, Coventry PA, Sticker CT, Clements C, Eaby B, Velders L, Rittenberg C, Gralla RJ. Validation and psychometric assessment of a short clinical scale to measure chemotherapy-induced nausea and vomiting: the MASCC Antiemesis Tool. J Pain Symptom Manage. 2007 Aug; 34(2): 148-159. The MASCC Antiemesis Tool® (MAT) was developed by members of MASCC to assist patients and oncology professionals in communicating accurately about the prevention and control of nausea and vomiting that may occur with chemotherapy. The concept of the MAT is to provide an easy-to-use and easy-to-evaluate tool to assist in providing the best individual care to patients. Additionally, the tool will aid treatment centers in understanding the effectiveness of their antiemetic treatment. Available in print and on iPhone/iPad apps.

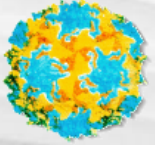
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Wikis

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



ganfyd

navigation

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- [Community portal](#)
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[category](#) [discussion](#) [view source](#) [history](#)

Category:Palliative care medicine

Palliative care medicine is the branch of medicine concerned with ameloriating symptoms in diseases that cannot be cured.

Symptoms

- [Nausea/vomiting](#)
- [Pain](#)
- [Dry mouth](#)
- [Secretions](#)
- [Dysphagia](#)
- [Agitation](#)
- [Mental, emotional and spiritual aspects](#)

Diseases

- [Cancer](#)
- [Heart failure](#)
- [Multiple sclerosis](#)
- [Motor neurone disease](#)

Pages in category "Palliative care medicine"

The following 5 pages are in this category, out of 5 total.

C

- [Chronic pain](#)

M

- [Marie Curie nurses](#)

P

- [Pain management in palliative care](#)

T

- [Tender loving care](#)
- [Terminal care](#)

Wikis: HemOnc



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Drug index
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Billing codes
GVHD
Antiemetic support
Vesicants & irritants
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HemOnc.org - A Free Hematology/Oncology Reference

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1,723 regimens on HemOnc.org

2,302 variants on HemOnc.org

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!

[Mobile/tablet version of the main page](#)

[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

Wikis: Wikipedia



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La enciclopedia libre

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Portal de la comunidad
Actualidad
Cambios recientes
Páginas nuevas
Página aleatoria
Ayuda
Donaciones
Notificar un error

▼ Imprimir/exportar
Crear un libro
Descargar como PDF
Versión para imprimir

► Herramientas

▼ En otros idiomas

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Deutsch
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Euskara
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日本語
Nederlands
Norsk bokmål
Srpskohrvatski /
српскохрватски
中文

Editar los enlaces

[Crear una cuenta](#) [Ingresar](#)

Artículo **Discusión**

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Buscar

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 asociaciones 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]

- 1 En la medicina paliativa
- 2 Procedimiento
- 3 Reflexiones críticas
- 4 Bibliografía
- 5 Referencias

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 **anestesiista** 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 tendientes 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 informe 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 utilizada 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



Midazolam...



Ketamina



Blogs

Blogs

- Sitios web en que uno o varios autores publican artículos
- Los artículos se almacenan generalmente de forma cronológica
- Los usuarios pueden insertar sus opiniones como comentarios
- Algunos son profesionalizados y solo publican artículos profesionales autorizados

Blogs: Pallimed



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

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by Debbie Parker-Oliver

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...

96

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Monday, January 11, 2016 by Pallimed Editor -



Looking Ahead at 2016 for Palliative Care

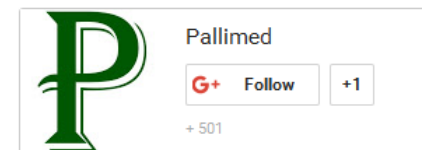


by Christian Sinclair 2015 was a pretty exciting year in palliative care, but

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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Blogs



Hospice and Nursing Homes Blog



Journal of Palliative Medicine

PALLIATIVE CARE SUCCESS

HOSPICE DOCTOR

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Podcasts

- Los Podcasts son sistemas de transmisión de información en forma de ficheros de audio o video
- Se descargan de sitios web determinados o se obtienen por redes de suscripción RSS
- Se reproducen mediante reproductores MP3 o en el ordenador
- Pueden estar profesionalizados

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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A Discussion of Hospice Eligibility and Recertification

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

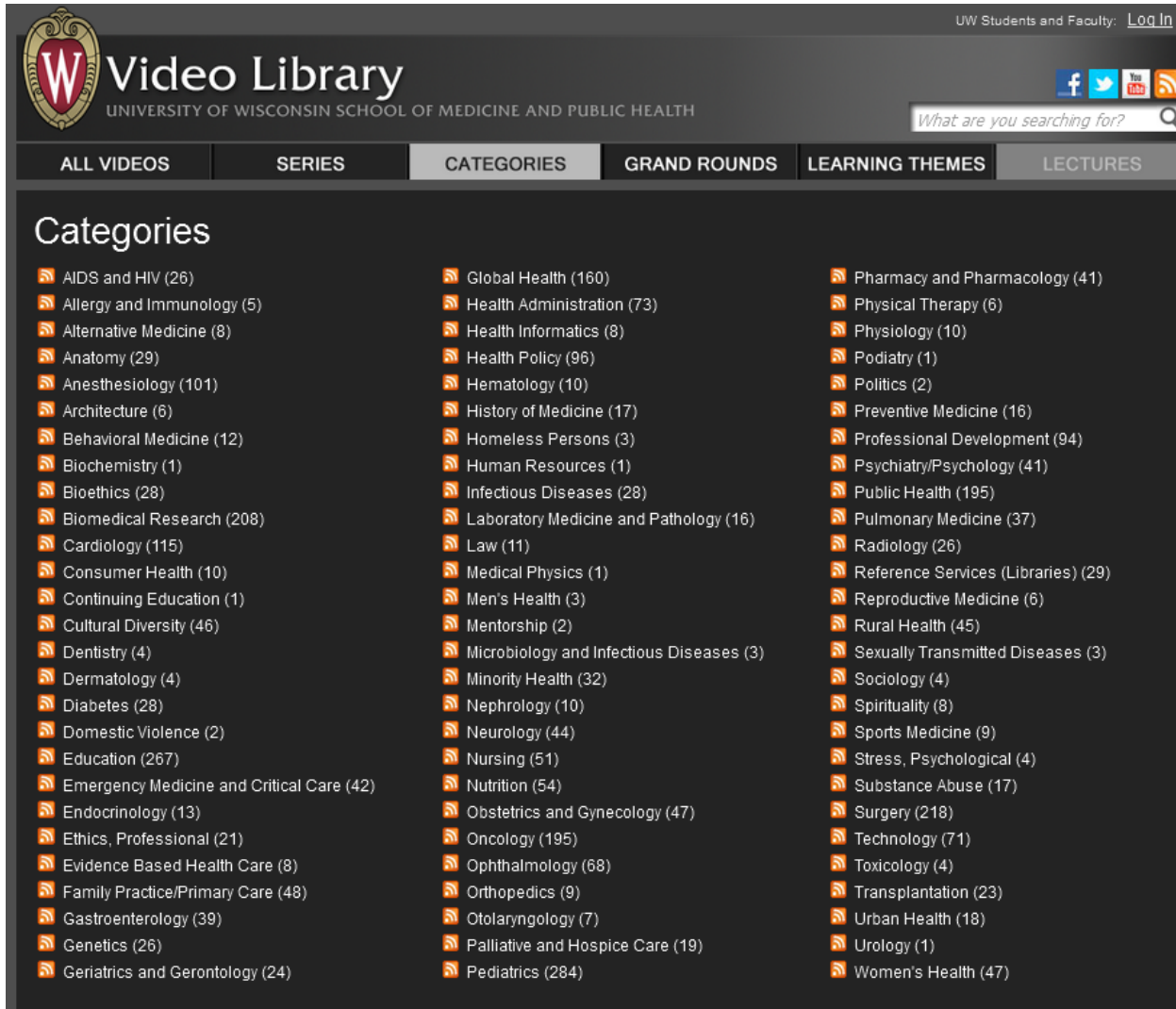


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Videos profesionales

Videos profesionales



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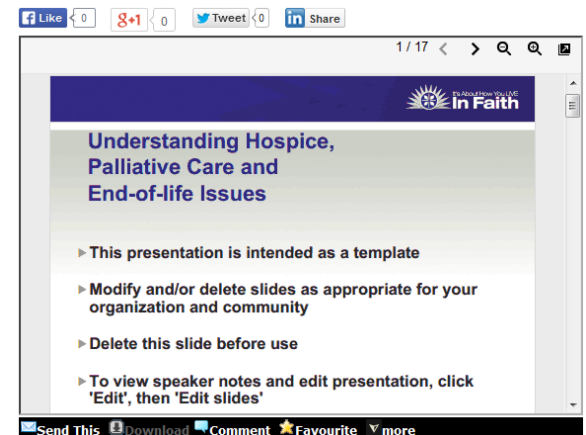
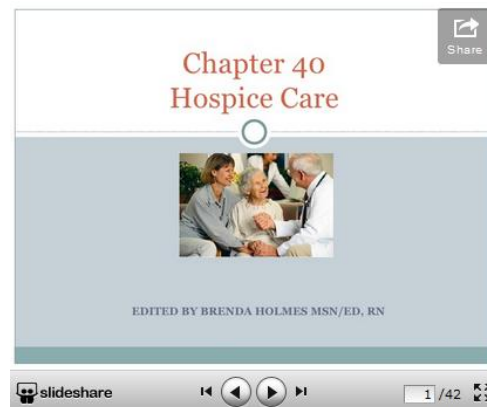
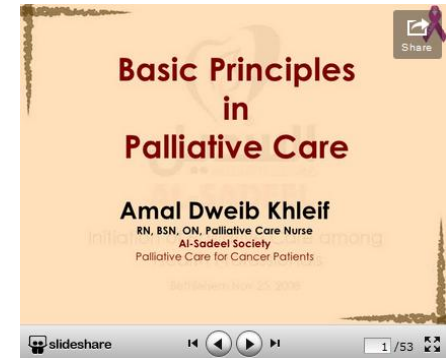
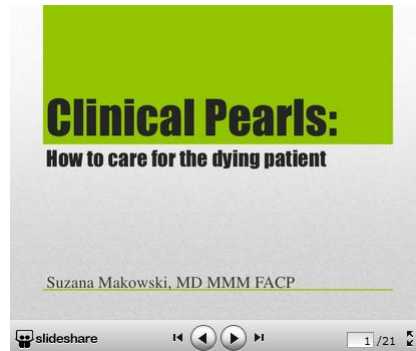
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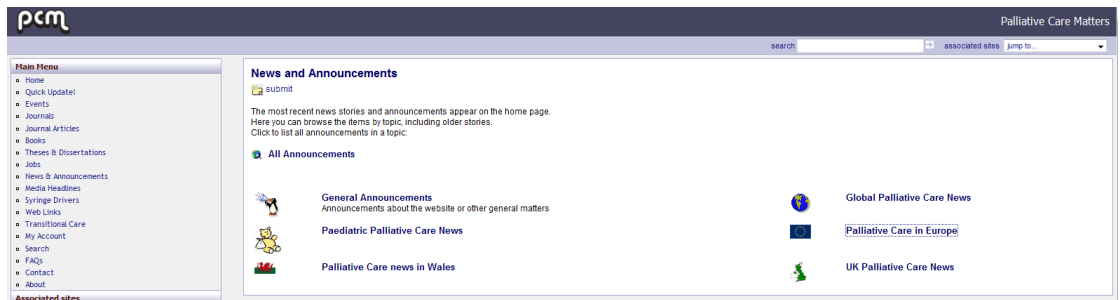
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Noticias: Edición profesional



Palliative Care in Europe

Topics » [Palliative Care in Europe](#) [submit]

ESMO publishes Clinical Recommendations on cancer pain

Monday 20th June

The European Society for Medical Oncology has published a new issue of Annals of Oncology containing 35 updated and new Minimum Clinical Recommendations, including the management of cancer pain.
http://www.esmo.org/reference/reference_guidelines.htm

European Parliament report - Rules hinder access to Opioids

Sunday 19th June

Disparate and outdated Government policies and regulations on the use and prescription of opioids contribute to the inadequate treatment of pain across Europe, according to a new report, presented to the members of the European Parliament today.

Palliative Care a priority topic on the European Health Agenda

Friday 23rd January

The project "Making Palliative Care a Priority Topic on the European Health Agenda" was discussed today at a EURAG conference (European Federation for Older Persons).

ESMO Designated Centers of Integrated Oncology and Palliative Care

Monday 8th September

The ESMO (European Society for Medical Oncology) Palliative Care Task Force seeks to identify and support exemplary programs through a "Designated Centers of Integrated Oncology and Palliative Care" program.

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Comunidades



Hospice Care

National Hospice and Palliative Care Organization

Center to Advance Palliative Care

American Academy of Hospice and Palliative Medicine

Hospice Support Group

Hospice Action Network

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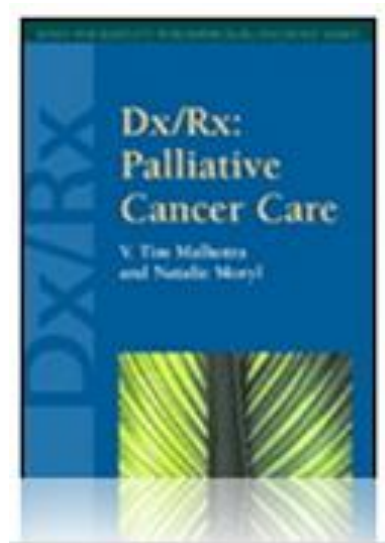
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Aplicaciones móviles



GP Pain Help
Australian College of R

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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.

Source/Smartphone
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Pallimed

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.

Source/Smartphone
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Dx/Rx: Palliative Cancer Care

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outline bulleted format, this handy
reference details precise, up-to-date
information on palliative cancer care.
Throughout the reference, tables and
figures summarize important clinical data
and current prof...