BLOGS TO BOARDS – QUESTIONS ONLY HANDOUT

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Question HPM1

Ms. V is a 68 year old with metastatic non-small cell lung cancer, congestive heart failure, and mild renal insufficiency residing in an inpatient palliative care unit for management of bone pain. Her medications include morphine IR, fentanyl transdermal patch, furosemide, senna, and Fleet enemas prn. Ms. V did not have a bowel movement in 4 days. Basic labs were ordered for the next morning as well as a two of her prn enemas, although they failed to result in a bowel movement. The labs the next day reveal a serum sodium of 124, potassium of 3.0, creatinine of 1.4 (baseline of 1), low calcium of 6.5, and a very elevated phosphate of 17 mg/dl.

What is the most likely cause of her electrolyte abnormalities?

a) A medication adverse event
b) Tumor lysis syndrome
c) Bowel Impaction
d) Osteolytic metastases

Question HPM2

Walking into a room at your hospice inpatient unit you see a tired appearing female patient lying in bed with soft moaning, holding her abdomen. She has end stage CHF and no history of cancer. Review of your notes show decreasing oral intake and increased time in bed. Her nurse reports she disimpacted her yesterday after suppositories and enemas were ineffective for worsening constipation.

Medications include:
Fentanyl 50mcg patch (on for several weeks)
Senna 2 tabs BID
Colace daily
Recent enema, and docusate suppository

Exam:
Cachectic female
Scaphoid abdomen, hypoactive bowel sounds, formed (but not hard) stool on rectal exam.

What is the next best plan for action?

a) Write an order for methylnaltrexone 8mg subcutaneously x1 now.
b) Switch her from a fentanyl patch to a morphine pump so you can better manage her abdominal pain.
c) Write an order for octreotide 200mcg subcutaneously twice daily for three days
d) Place an NG and give her polyethylene glycol daily until she has a bowel movement or regains ability to swallow and you can remove the NG tube

Question HPM3

During a hospice interdisciplinary team meeting, you hear about a 53-year-old resident of the local nursing home. He has ALS with bulbar attributes, and is starting to have difficulty swallowing and speaking. He is bedbound most of the day. He has had two episodes of aspiration pneumonia in the last month.

His nurse describes the scene with the patient's wife, Sally, at his side, squeezing his hand with one hand and her rosary with the other. He explained to the nurse, "I told Sally that I don't want a feeding tube. I've had a good life and have few regrets. I saw my father-in-law die on a feeding tube and I would not want to go through that, or put my wife through that. But I am Catholic. Our friend at the parish said that I have to 'do everything' to prolong my life – especially when it comes to nutrition - or I will go hell. I don't want to go to hell." His wife nods emphatically.

During the interdisciplinary care meeting, the chaplain (in his role as teacher) asks you to explain to the team what your understanding of the Catholic doctrine is as pertaining to this patient.

What do you say?

a) My understanding is that medically assisted nutrition is obligatory for patients who are unable to take food by mouth.
b) My understanding is that medically assisted nutrition is morally optional for most patients at the end of life.

Question HPM4

Mrs. Dole, a 68 year old with 20-year history of Diabetes Mellitus Type II is referred to Palliative Care from Oncology with Stage III Nasopharyngeal carcinoma. Nausea is the key concern. For last 3 years she has had early satiety but maintained weight. Since initiating chemotherapy, she has had nausea for the first 2 days of her chemotherapy cycle, which then resolves.

1 week after the last round of chemotherapy she required intravenous fluids for dehydration. Now 2 weeks later is having intermittent severe nausea. It can be provoked by sudden changes in body position. She fell once because she lost her balance. Usually she does not vomit, but occasionally does. She describes a feeling of the room spinning associated with the nausea.

Of the following options, which drug is most targeted to this patient's specific nausea type:

a) Ondansetron
b) Prochlorperazine
c) Metoclopramide
d) Diazepam
e) Meclizine

Question HPM5

In hospice IDT, you discuss the case of a 68 year old female with ovarian cancer with abdominal pain and sudden onset nausea and vomiting. She has had no recent bowel movements and is on minimal opioids. You suggest a trial of octreotide for a likely malignant bowel obstruction and the nurses say "Doctor! You say we can use octreotide for everything! Is there anything octreotide can't be used for in hospice?"

Which one of the following is not a potential scenario to use octreotide? Choose the best answer.

a) *A 37 year old male with end stage alcoholic hepatitis who starts vomiting blood*
b) *A 90 year old with a severe diarrhea with a history of a rectal tumor and radiation burns to the perineal area*
c) *A 42 year old female with a tense distended abdomen leaking a small amount from a previous paracentesis site.*
d) *A 27 year old male with a malignant wound with copious drainage*
e) *A 31 year old female with abdominal pain from opioid-induced constipation*

Question HPM6

You visit a patient at home receiving hospice care for cancer. Her pain has been well controlled with long acting morphine 60mg BID and occasional PRN doses of short acting liquid morphine (10mg) over the past few weeks: she had been tolerating this well. She has had recent progressive functional decline and is currently at a PPS of 20%. In the last 24 hours the patient has vomited and has been more lethargic and having difficulty swallowing pills. She appears uncomfortable. In your examination you see a very thin patient who appears to be dying with a prognosis in the few days to a week range.

The patient's son is a respiratory therapist at a hospital and is insisting you change the patient's opioid to a fentanyl patch because "it is less sedating than morphine."

The best response is:

Answers

a) *Because the patient is cachectic, you tell the family that fentanyl transdermal patches are not indicated because the medication will not be absorbed.*
b) *Agree with the son and convert the patient to a 37.5mcg/hr fentanyl patch with oral morphine liquid 10mg q1 hour PRN*
c) *Because the fentanyl will not be effective for over 24 hours, continue the long acting morphine sulfate 60mg BID but give it rectally instead of by mouth*
d) *Suggest starting a morphine infusion via her port at 1.7mg/hr basal with a 3mg q30min bolus PRN after talking with the son about his concerns about sedation.*

Question HPM7

JY, a 28 year old woman with advanced cystic fibrosis and Burkholderia cenocepacia colonization is hospitalized for a cystic fibrosis exacerbation. She has chronic chest wall pain from coughing and pleurisy, and recently broke 2 ribs from coughing. She is on IV glucocorticoids, IV ketorolac, IV ketamine prior to vest treatments, and lorazepam. Prior to her hospitalization, she took oxycodone ER 30mg q12h. Currently she is on a hydromorphone IV PCA at 2mg/hour, with 2mg q30 minute boluses. She used 72mg of IV dilaudid in the last 24h.

Despite this she is becoming drowsy, and reports her pain is minimally improved and still severe for most of the day: 7-8/10, and 'nearly intolerable' during vest therapy

The best next step is to:

a) *Increase her PCA basal and 'bolus' doses by 50% and monitor for 24 hours.*
b) *Add a 5% lidocaine patch to her chest wall over her rib fractures*
c) *Discontinue hydromorphone and switch the patient to another opioid*
d) *Advise the primary team to stop vest therapies*

Question HPM8

Mr. Smith is a 72 year old patient was admitted to hospital from his nursing home for respiratory distress due to CHF exacerbation. Despite aggressive diuresis attempts, his respiratory distress continued and his urine output remained minimal (~30ml/day).

PMH: heart failure, moderate dementia, renal insufficiency
Home medications: furosemide 40mg po bid, metoprolol 25mg bid, donepezil 10mg daily, olanzapine 5mg qhs.

After a conversation with his son (health care proxy) the patient was "made CMO" (comfort measures only) by the hospitalist service and resident team two days ago. He was then started on a morphine drip "titrate by 1mg as needed for pain or shortness of breath", his donepezil, olanzapine and diuretics continued, other medications stopped.

His intern calls in a panic: "We promised to make him comfortable, that he would die in 2 days, but he is still alive and the family does not know why he is in such pain – even with light touch – crying out & jerking."

What is your recommendation?

a) *Stop morphine drip and start fentanyl and lorazepam prn*
b) *Increase morphine and olanzapine*
c) *Increase morphine and add lorazepam prn*
d) *Stop morphine drip and start fentanyl, increase olanzapine*

Question HPM9

BJ, a 65 yo woman with known non-small cell lung cancer, metastatic to her mediastinum, contralateral lung, and supraclavicular lymph nodes, returns to your clinic for follow-up for her cancer-related pain. She is getting chemotherapy, and has always expressed a desire for 'the most aggressive' treatments available for her cancer.

She complains of 2 weeks of worsening, midline low back pain. She has noticed difficulty in rising from chairs/toilet, and needed a wheelchair to make it into the clinic area today from the parking garage due to weakness. Examination is notable for an unremarkable back/spine exam, and 4/5 strength bilaterally in her lower extremities both proximally and distally. You obtain a stat MRI which shows a T12 vertebral metastasis and cord compression.

In addition to administering glucocorticoids, then next best step is to:

a) Arrange an urgent radiation oncology consultation for the next day.
b) Admit her to the hospital, and arrange a stat radiation oncology consultation.
c) Admit her to the hospital, and arrange a stat spine surgery consultation.
d) Adjust her pain medications appropriately, and instruct her to contact you immediately if her pain or disability worsens

Question HPM10

Mr. G. Da Salva is a 68 year old construction worker who has metastatic non-small cell lung cancer involving his right femur and pelvis.

Medications include: Morphine ER 200mg bid, Morphine IR 30-60mg PO q2 hours prn, and dexamethasone 8mg daily. At rest his pain is well managed, 2/10.

However, he fears movement due to severe pain and spends most of the day in his recliner, avoiding showering or changing or helping with the meals. He uses approximately 5 doses daily of 60mg short-acting morphine 6for this pain but once it starts to work the pain has often spontaneously subsided and he becomes very sleepy and confused.

Which of the following is LEAST appropriate?

a) Take a short-acting morphine prior to a clustering his activities: showering, changing, fixing a meal.
b) Add sublingual fentanyl 200mcg to take prior to his activities.
c) Increase his long-acting morphine to 200mg tid.
d) Single-fraction radiation therapy to his pelvis and femur.
e) Intrathecal pump with morphine and low-dose bupivacaine.

Question HPM11

Mr. Z is a 87 year old with advanced dementia living in a nursing home. At baseline he cannot recognize family members, is dependent on all ADLs (dressing, toileting, bathing) but does not have urinary or fecal incontinence. He speaks about 1-2 intelligible words per day and he has had progressive loss of ability to ambulate. He is now admitted to the hospital after sustaining a hip fracture from a fall.

When discussing treatment options for his hip fracture, his wife asks you how long he likely has to live.

Given his current state of health, what would be the most appropriate answer:

a) Given that he does not meet FAST 7C criteria his prognosis is likely greater than 6 months
b) He meets NHPCO Guidelines for hospice eligibility which means he likely has less than a 6 month prognosis
c) Given his advanced dementia and recent hip fracture, his 6 month mortality risk exceeds 50%
d) As with most individuals with advanced dementia, his life expectancy is likely weeks to months

Question HPM12

Mrs. A is an 88 year old with advanced dementia who lives in a nursing home. She has at baseline some difficulty with eating as she pockets food in her mouth and occasionally coughs after swallowing. She is now hospitalized for an aspiration pneumonia. In addition to the antibiotics she is on in the hospital, her only other medications include HCTZ for hypertension and a baby aspirin. She has never taken a cholinesterase inhibitor.

What is the best next step?

a) A trial of both a cholinesterase inhibitors and memantine
b) Feeding tube insertion
c) Careful hand feeding and good oral care
d) Addition of olanzapine to treat her pocketing of food behavior

Question HPM12 – Part 2

The family is concerned that Mrs. A aspirations will continue if she continues to b fed by hand in the nursing home. They would like to know about more about the risks of a feeding tube placement.

The most appropriate risk to include in the discussion is:

a) She will have a 1 in 10 chance of a major surgical complication in the perioperative period,
b) She is unlikely to have a tube related complication after the perioperative period

c) *Once the tube is placed, it would be technically difficult to electively remove the tube*
d) *She will have a 1 in 3 chance of requiring chemical or physical restraints to prevent tube removal*

Question HPM13

A 54 yo man with a 7 month history of metastatic bladder cancer presents to the cancer center's palliative care clinic. He complains of low mood, anhedonia, feelings of guilt, shame, and worthlessness most days for the last 2 months. He says, "Of course I'm depressed – who wouldn't be? I've got a cancer that the doctors tell me is terminal. What good am I to my family? They'd be better off without me."

The best next step would be to:

a) *Counsel the patient that he is depressed and recommend a treatment plan for it.*
b) *Ask your team's social worker to see the patient for grief counseling.*
c) *Provide emotional support and counseling with the patient that what he is experiencing is part of the expected adjustment to having a terminal illness.*
d) *Refer the patient to psychiatry for complicated depression.*

Question HPM14

The patient agrees to pharmacologic therapy for his depression, and declines offers of counseling/therapy. Your best estimate is that he has 4-8 weeks to live based on performance status and tempo of decline.

Which of the following are appropriate drug approaches for his depression?

a) *Methylphenidate*
b) *Ketamine*
c) *Dronabinol*
d) *Sertraline*

HPM14 part 2 - Antidepressant Pop Quiz!

I say depression, insomnia, anorexia, nausea – You say:
- a) *Trazodone*
- b) *Paroxetine*
- c) *Mirtazipine*
- d) *Escitalopram*

I say depression, anxiety, insomnia, neuropathy, You say:
- a) *nortriptyline*
- b) *duloxetine*
- c) *fluoxetine*
- d) *venlafaxine*

I say activating antidepressants, You say
- a) *fluoxetine*
- b) *paroxetine*
- c) *buproprion*
- d) *citalopram*

I say depression, anxiety, neuropathic pain, advanced age, You say:
- a) *duloxetine*
- b) *nortriptyline*
- c) *paroxetine*
- d) *mirtazapine*

Question HPM15

Mrs. Phillips is a 91-year-old hospitalized patient who is now actively dying due to end-stage pulmonary fibrosis and asbestosis. She has been well palliated during the last several months at home where she lived independently, until she developed a pneumonia and was hospitalized. Her home medications had not been adjusted in over six weeks. This included: albuterol and atropine nebulizers, dexamethasone 2mg every morning, 25mcg/hour fentanyl patch for dyspnea, oxycodone concentrate (20mg/ml) 10mg q2 hours prn dyspnea or pain, senna and Colace. She is on day 7 of oral antibiotics for presumed pneumonia. She is on oxygen 6 liters via nasal cannula. Her last bowel movement was yesterday, and her urine output has been good (250ml or more daily.)

Yesterday she was still oriented, between periods of increasing fatigue and sleep. She showed signs of mottling and new secretions causing respiratory rattle. A scopolamine patch 1.5mg was started for her increased secretions.

You are called by the resident who explains to you that this morning Mrs. Phillips is now agitated, moaning, and even thrashing at times. This is causing family and floor nurses distress. He asks you for advice.

Which of the following is appropriate?

a) *Stop scopolamine*
b) *Start lorazepam*
c) *Increase the fentanyl*
d) *Stop the fentanyl*
e) *Counsel family about the inevitability of terminal delirium*
f) *Order soft restraints*

Question HPM16

Mr. J is 58 year old diagnosed with ALS 6 months ago. He is referred to your clinic by his primary care doctor to help discuss options to treat a progressive weight loss. He currently lives alone in an apartment, is independent of ADLs although he has been having difficulty feeding himself due to proximal arm weakness. He complains that he occasionally bursts out crying or laughing, but denies feeling depressed. His forced vital capacity (FVC) has remained at 70% for the last 3 months.

The best treatment to help treat his progressive weight loss?

a) Riluzole
b) PEG Placement
c) Mobile arm supports and modified cutlery
d) Non Invasive Positive Pressure Ventilation (NIPPV)

Question HPM17

Mr G is a 74 year old nursing home resident with coronary artery disease and end-stage renal failure (eGFR of 12). He is considering starting treatment with dialysis but would like to know more about what life will be like after starting dialysis.

What would be the most accurate statement in regards to his prognosis

a) His functional status is likely to improve with renal replacement therapy
b) His functional status is likely to be maintained at his pre-dialysis level
c) He is unlikely to have significant symptom burden if he elects not to initiate dialysis
d) The majority of nursing home residents die within one year of starting dialysis

Question HPM18

George Condi is a 68 y/o male is admitted to ICU for respiratory crisis and found to have renal cell carcinoma with a 13 cm mass in the R upper abdomen. He has severe pain, and dyspnea with large R sided pleural effusion. With drainage of effusion his dyspnea is improved; a tunneled pleural catheter is placed, and he is discharged to home hospice with a PPS of 50.

The next day his wife calls saying she can't manage the catheter and she is in tears because his pain is 6/10 and he is more short of breath. "You promised me it wouldn't be like this!" She wants to take him to the emergency room for IV furosemide and a pulmonologist visit.

The best approach is to:

a) Arrange for a hospice nurse to meet the patient in the emergency room to disenroll him from hospice
b) Set up in home continuous care to manage his catheter
c) Immediately prepare a respite stay
d) Admit the patient to a qualified skilled nursing facility for General Inpatient stay for pain control

Question HPM19

George is admitted to GIP status in a skilled nursing facility with 24 hour RN availability. He has had a marked decline since he was seen 2 days ago. The hospice nurse is asking whether the plan should be to send him back home after the symptoms are controlled. The social worker doesn't want to bring that up because it might upset the wife and because it might give George false hope. The entire Interprofessional group thinks he might die in the next week or two

You reply that:

a) Since he'll likely die in 7-10 days, it will be fine to continue on General Inpatient Status for imminently dying criteria so discharge discussions don't need to be raised
b) Due to the wife's burden of caregiver distress, the patient will be maintained on General Inpatient Status for caregiver breakdown so discharge discussions don't need to be raised
c) Once admitted to General Inpatient Status, one of the goals must be transition to a lower level of care
d) Since General Inpatient status should only last 7 days, discharge discussions will start after the first 3 days to let the family have some relief.

Question HPM20

Mrs. Tagliatelli is a 76 year old Italian immigrant and widow who has not missed a day of mass in her adult life until this past month. She comes to see her primary care physician in clinic because she missed mass, asking whether she should get hospice. She has heart failure, mild hypertension, and sleep apnea.

She has noted that over the last month, her legs are more swollen and she is having increased difficulty walking to church and the grocery store. She still keeps an impeccable home, managing her housecleaning herself, but now is sitting down for a longer period of time after carrying the vacuum up and downstairs. She is also able to maintain her daily rituals of reading the NYTimes Health and Travel sections, cooking three small meals each day.

She no longer wishes to return to hospital, and has not been admitted since her myocardial infarction 5 years ago, which

preceded her diagnosis of heart failure. At that time, she had a successful resuscitation and wishes to remain full code.

She uses CPAP at night for her sleep apnea, but otherwise does not require oxygen. She also tells you that because she lives alone, she keeps a gun in her home for self-protection.

Her home medications include: Furosemide 10mg BID, Atenolol 50mg daily, lisinopril 10mg daily, simvastatin 5mg daily, aspirin 81mg daily. She also has nitroglycerine 0.4mg sl prn (which she has not used since her MI), and acetaminophen 325mg which she takes "once in a while for an ache."

Why would this patient not be admitted to hospice?

a) She is full code.
b) She lives alone.
c) She has greater than a six-month prognosis.
d) She is not homebound.
e) *She has firearms in the home*.

Question HPM21

A couple of years and hospitalizations later, Mrs. Tagliatelli was admitted to hospice. At the time of admission to hospice, she was breathless with minimal exertion. Neighbors and members of her church visited her often offering her food, company, and rides to church. She required oxygen all the time. Even with this, at the time of admission to hospice, she experienced constant dyspnea.

Her cardiac medications were continued, morphine ER and IR were added for her dyspnea.

After six months on hospice, she is now well palliated, especially since she has been able to have her medications as prescribed and no longer spaces out her medications in order to make them last. However, she continues to require help from her friends and neighbors, and oxygen with minimal activity. She fell once and required a trip to the emergency department. You go to see her for recertification visit.

What do you write in your recertification note?

a) She meets criteria for recertification because her prognosis remains 6-months or less.
b) She does not meet criteria for recertification because she has not shown decline in her condition.
c) She does not meet criteria for recertification because her last hospitalization was unrelated to her hospice diagnosis

Question HPM22 – Part 1

A young man was recently in a motor vehicle collision where he suffered a massive head injury and multi-trama. He was resuscitated and survived in the ICU with a ventilator, continuous hemodialysis, and multiple pressors for the past 2 days, but now he is clearly declining rapidly. You receive a palliative care consult to help with the ventilator withdrawal. You head down to the unit and the nurse comes to you and says "I am not sure you should talk with the family – the organ procurement agency has just visited to discuss organ donation after cardiac death, and the family want to donate his organs – his liver and lungs may be transplantable."

What is the best next step?

a) Thank the nurse, and back out of the consult
b) Talk with the family about the patient, their grief, and counsel them about comfort care after cessation of life-support.
c) Ask the attending physician of record who is going to manage the patient's comfort care after cessation of life-support.
d) Work with the family to help them realize this will only prolong the patient's suffering.

Question HPM22 – Part 2

A day later, the patient's HCV test comes back positive and he is no longer a viable DCD candidate. The ICU attending asks you to 'take care of the treatment withdrawal'. The family is very disappointed, and ndicates their only goal at this point is for a comfortable death, without 'prolonging this any longer.' His only symptom-directed med is intermittent fentanyl bolus (700mcg the last 24h). He is unresponsive on the vent, without any spontaneous movement.

The best next step is to:

a) Recommend rapidly stopping all life support including CRRT, ventilator, and pressors over the next hour or so, and starting a fentanyl and lorazepam infusion to keep the patient sedated.
b) Recommend staggering withdrawal of life support over a couple days including stopping CRRT and pressors now in the hopes that the patient dies on the ventilator.
c) Discuss with the family different approaches to life-support withdrawal.
d) Switch the patient from fentanyl to morphine boluses as you extubate him, as morphine is more effective for air-hunger.

Question HPM23

A 47 year old woman with a severe, idiopathic, dilated cardiomyopathy is receiving hospice care at home. She is ineligible for cardiac transplantation or a ventricular assist

device. She has mild resting dyspnea but becomes severely dyspneic after just a few steps of ambulation. Her nurse measures her resting and ambulatory oxygen saturation while breathing ambient air: it is 96 and 92%, respectively. The patient is taking digoxin, bumetamide, hydralazine, isosorbide dinitrate, albuterol MDI, warfarin, senna, and clonzepam. The patient requests home oxygen therapy to help alleviate her breathlessness.

The best response is:

a) Order home oxygen therapy for the patient
b) Initiate lorazepam prn for dyspnea
c) Recommend use of a hand-held fan and prn morphine for her dyspnea
d) Request that the patient see her cardiologist for further optimization of her heart failure meds

Question HPM24

Mr. L is a 52-year-old homeless man. One week ago, he was admitted to the ICU with respiratory distress and was intubated. A chest CT scan revealed a large necrotic mass filling the right hemithorax, obliterating the right and narrowing the left mainstem bronchi. Sputum cytology confirmed a diagnosis of non-small cell lung cancer. Oncology states that there is no role for chemotherapy or radiation unless he could be weaned off the ventilator, which was considered doubtful in the setting of his airway obstruction.

Mr. L is unable to participate in medical decision-making. The patient's mother, who is the authorized decision maker, meets with the palliative care team to discuss prognosis and treatment options, including withdrawal of life-sustaining treatments. The mother is adamant that all life-sustaining measures be continued despite a previous discussion that Mr. L's disease severity will prevent him from ever leaving the ICU, let alone the hospital. Mr. L's mother expresses hope that, despite the physician's prediction, a miracle will occur that will allow her son to leave the hospital.

The next best step is to:

a) Schedule another family meeting to reiterate the prognosis of his current condition and the likelihood of recovery
b) Involve an ethics committee as the mother's belief in a miracle is far from a societal norm
c) Tell the mother that hope for a miracle is unreasonable, but that she could still hope that her son is comfortable
d) Ask the mother about her spiritual beliefs and how it influences her decision

Question HPM25

Omar Johnson is a 64 year old man with cryptogenic cirrhosis in multiorgan system failure in your hospital's ICU. He is ventilated, unresponsive, and on vasopressors. You and the ICU team agree his chances for surviving this hospitalization are minimal. He has no advance directive.

You participate in an ICU family care conference with his wife (his legal decision maker based on state law), 2 sisters, and 3 adult sons. They are told he is dying with minimal chance of survival.

His sons say they do not think the patient would want to die 'like this – on machines,' and describe several conversations with the patient to support that preference. His wife seems to reluctantly agree with that, but also says, "I can't give up on him. I can't have that on my shoulders – I'll always wonder if I did the right thing."

The best, next response would be:

a) Request ethics consultation
b) Along with the ICU physician, suggest to the family that you make the decision on behalf of the patient yourselves, to transition the patient to comfort-care.
c) Ask the family to focus on what the patient himself would prefer in these circumstances.
d) Express to the family acknowledgment of the emotional difficulty of this, and recommend another meeting the next day.

Question HPM26

Mrs. Hassad is a 83 year old retired professor from Iran who is being evaluated for a hospice admission. Her 4 sons live in adjacent homes with their families. She has metastatic breast cancer with bone, liver, and brain. Because of her underlying renal failure and moderate heart failure, she will not be receiving chemotherapy and her physician had arranged home hospice services now that she has completed palliative radiation. She is alert, oriented.

The hospice intake nurse calls you because the family and patient state that she does not want to know anything about his diagnosis or severity of illness. Mrs. Hassad's son tells the nurse not to speak with the patient about her prognosis, her illness, or about code status. You are at the home with the nurse because she does not know how to get her to sign the paperwork to enroll in hospice.

What do you do after confirming with Mrs. Hassad that she does not want to be involved in signing papers or knowing details of his medical condition?

a) Explain to the son that you must gain consent from Mrs. Hassad in order to enroll her in hospice in respect of the principle of autonomy.
b) Invoke the health care proxy and have Mrs. Hassad's son sign the paperwork to enroll in hospice.

c) *Have the son sign the paperwork for hospice since Mrs. Hassad made the autonomous decision to defer decisions to her son.*
d) *Refuse hospice enrollment for the patient since she is unwilling to accept to address her diagnosis and prognosis.*
e) *Clarify to the patient that it is her responsibility to make the decision, based on autonomy, and to avoid trauma of surrogacy in her son.*
f) *Teach the nurse that she should not have questioned the son's request because that was disrespectful to their culture.*

Question HPM27

Dr. L is a 44 year old palliative care fellow about to complete two months of a busy inpatient consult rotation. You notice that over the last week she has become detached and disengaged when talking with patients and their family members. The fellow acknowledges feeling tired and drained most of the time, as well as having difficulty falling asleep. She also confides in you a personal sense of failure and self-doubt.

The most appropriate interventions at this time is

a) *Recommend she see her primary doctor to discuss SSRI therapy*
b) *Recommend she try bright light therapy*
c) *Refer for a transient mirrectomy*
d) *Recommend an educational program in mindful communication*

Question HPM28

Your palliative care clinic team meets Nancy Bush a 46 year-old with newly diagnosed triple-negative metastatic breast cancer. She has 7 and 11 year old children. The children know Nancy has been 'to the doctor' a lot lately but nothing else.

She is thinking about talking with the children and letting them know her diagnosis, but her mother thinks that telling them now will be too hard on them.

You advise:

a) *It is best to wait until Nancy's disease is obvious to the children so their interactions with their mother will not change.*
b) *Telling the children now will make them too anxious.*
c) *She should tell the older child, but the younger child is not at an appropriate development age that he will benefit from hearing his mother has cancer.*
d) *Telling the children of the disease may make them less anxious*

Question HPM29

You receive a call from the hospice nurse about a new hospice patient, Mrs. Gardner, who had a large ischemic MCA stroke 4 months ago. She has not been able to eat, is unable to turn herself, and has developed a large stage IV decubiti on her low back.

The wound measures 10cm x 8cm and 1.2cm deep. It has some limited undermining and no tunneling. At the wound bed, the spine is visible. The bed of the wound reveals malodorous, necrotic purplish muscle and tissue with extensive serosanguinous drainage. The surrounding skin is intact.

Mr Gardner covers her wound with a cream but notes 'It just keeps getting deeper." The patient is turned q2 hours. The goal of care is to keep her comfortable and at home – a promise he made to her.
The hospice nurse asks you for orders to help manage the wound. She will order an air-mattress.

After washing the bed of the wound with normal saline, applying a thin layer of metronidazole gel to the base of the wound, what do you recommend for a wound care dressing?

a) *Pack wound with wet-to-dry dressing and cover with ABD pad every 3 days.*
b) *Pack wound with calcium alginate wafer and rope, cover with ABD pad every 3 days.*
c) *Pack wound with hydrocolloid dressing and cover with ABD pad every 3 days*

Question HPM30

A 45 year old man with HIV-AIDS comes to your clinic for follow-up for HIV-related neuropathy pain. He has long declined any antiretroviral therapy, and has consistently stated he wants supportive-only care focused on maintaining his quality of life. He has a CD4 count of 90 cells/mm3. 1 year ago it was 100. He reports worsening pain control which he relates to inability to swallow his morphine ER tabs (100 mg tid) much of the time. He reports mid-throat pain, and frequently chokes on the pills, 'gags' them back up. Examination reveals a thin man. Mouth demonstrates scattered white plaques on the palate which reveal a red base when scraped away.

Best next step is to:

a) *Prescribe Nystatin 'swish & swallow'; change morphine to 30mg elixir q4h scheduled.*
b) *Prescribe fluconazole; change MorphineER pills to to MorphineER 'granules' in pudding (such as 'Kadian' or 'Avinza' morphine formulations).*
c) *Prescribe fluconazole, change his morphine to methadone elixir, and recommend hospice care given his goals of care and prognosis.*
d) *Prescribe Nystatin 'swish & swallow'; change his morphineER to a fentanyl patch.*

Question HPM31

Ms. F is a 64 year old who you see in your palliative care clinic 2 months after the death of her husband in an ICU. She describes sadness over the loss of her husband, as well as waves of yearning, helplessness, and guilt over her decision to proceed with the terminal extubation of her husband. She reports sleep and appetite changes, as well as fatigue.

Which of the following in the most likely diagnosis?

a) Grief
b) Complicated grief disorder
c) Post-Traumatic Stress Disorder
d) Major depressive disorder

Question HPM32

You are awoken at 2am the day before your interdisciplinary hospice team meeting, by a nurse who just joined your hospice. She is visiting Mr. Gunter Liszt, an 89 year old who is on hospice with end-stage heart disease. He has an ejection fraction of 21%, is oxygen dependent. He was last hospitalized for recurrent pulmonary edema and systolic blood pressure in the 80s. During his hospitalization, he developed cardiorenal syndrome and has become oliguric, with a daily urine output of 80-100mls.

He is on Amiodarone 600mg daily, furosemide 40mg bid via PICC line, metoprolol 25mg bid, oxycodone 5mg prn dyspnea, lorazepam 0.5mg SL prn. He had been weaned off of his dobutamine drip a day prior.

He was discharged back to his nursing home with hospice services 4 days ago. During that time, he became increasingly somnolent, with peripheral mottling, and over the last 2 days has become anuric. His family was called by the nurse, and was notified that his prognosis was poor: likely hours to maybe days.

He is DNR/DNI and you learn that has an implanted pacemaker and defibrillator.

The family is at the bedside distraught, watching him, the nurse nervously explains. "He is actively dying, but every few minutes he jumps out of bed –the defibrillator is shocking him again and again. His heart rate is erratic and in the 150s. He is moaning from time to time. What can I do?"

What is the next best thing to do?

a) Comfort the family while waiting for the defibrillator company to send a representative out to deactivate the defibrillator.
b) Restart the dobutamine drip.
c) Start a morphine drip at 1mg/hour.
d) Tape a magnet to his chest over the defibrillator.
e) Give the patient lorazepam 1mg IV push now.
f) Review with the admissions team the importance of identifying patients with AICDs, and having associated goals of care about deactivation

Question HPM33, 34

A 40 year old man is at home receiving hospice care for metastatic bladder cancer to peritoneum, lung, pleura, and spine. His ECOG is 4. His back and chest wall pain had been well controlled on morphineCR 100mg bid, dexamethasone 4mg bid.

In the last week he has become progressive more dyspneic, such that he reports severe air hunger at rest, despite medication changes including dexamethasone 8mg bid, lorazepam 2 mg q6h, and transitioning to a morphine PCA which is now at 8mg/hour with a 8mg/10 minute PCA dose. He is normoxic on 4lpm of O2 by nasal cannula. He declines inpatient admission for evaluation and symptom relief. You think he has less than a week to live.

He tells you, "I can't go on like this – this is not how I wanted to die. Can't you put me sleep so I don't have go through this?"

After evaluation by the hospice interdisciplinary team, phone consultation with a colleague, and discussions with the patient and his family, you decide to sedate the patient to unconsciousness, with no plan of lightening the sedation

The best term to describe what the patient is asking for is:

a) Physician assisted suicide
b) Proportionate palliative sedation
c) Terminal sedation
d) Deep, continuous sedation

His medication treatment plan should include which of the following:

a) Escalation of his morphine continuous rate until he is unarousable
b) Anticholinergic medication to minimize retained oropharyngeal secretions
c) Intravenous normal saline to prevent dehydration
d) Bolus and continuous intravenous midazolam or pentobarbital to maintain a state of unresponsiveness

Question HPM35

Mr. Xiao is a 63-year-old edentulous Chinese immigrant, long-standing smoker who is on hospice for an unresectable fungating squamous cell carcinoma at the base of his tongue with metastasis to lung.

He is getting nutrition and medications through a feeding tube. His medications currently include: Methadone 70mg tid, oxycodone 60mg q2 hours prn, dexamethasone 8mg daily, scopolamine patch 1.5mg, topical viscous lidocaine mixed with thrombin powder swish and spit prn.

He and his wife come in distraught due to his pain, bleeding, and most of all the malodor. He also often gags on his own blood. He hopes to have his grandchildren visit soon, and does not want them to be put off by smell in his mouth. He tells you of a friend of his from the infusion suite who received a single-fraction of palliative radiation for his painful metastasis to his femur and asks if there is a similar approach for him. Due to the anatomy of the tumor, palliative embolization is not an option.

Which of the following treatment options is the most appropriate?

a) Single-fraction radiation
b) Hypo-fractionated Radiation therapy
c) Standard radiation therapy

Question HPM36

You are a medical director for a hospice agency.
MF, an 83 yo woman with metastatic breast cancer leading to bone marrow infiltration and chronic cytopenias has been receiving hospice care at home with your agency for 2 months. She is ambulatory, and spends half her time in bed or a chair due to weakness and fatigue, but rates her quality of life as very high. She has confirmed with her RN case manager her goals are to have as good a quality of life as possible, but is not interested in further treatments to prolong her life.

At a follow-up visit with her oncologist who is her hospice attending physician, MF complains of worsening and distressing fatigue. The oncologist orders a CBC, which showed a hemoglobin of 7.4mg/dL and a hematocrit of 23. 3 months ago they were 9.5mg/dL and 29. She orders a transfusion of 2U PRBC; the patient indicates interest in receiving it.

You call the oncologist to discuss the transfusion and she says tells you it has helped the patient's fatigue in the past and hopes it will help her now.

The best next step would be to:

a) Decline to cover the costs of the transfusion as it is unrelated to the patient's 'terminal' diagnosis
b) Agree that the hospice will cover the costs of the transfusion, and will monitor her for signs of improvement
c) Recommend that the patient receive oral iron supplementation and methylphenidate
d) Discharge the patient from your agency's care, as she has chosen to seek life-prolonging treatments for her cancer.

Question HPM37

JW is a 48-year-old female with metastatic renal cell osteosarcoma of her L pelvis (mets to lung and spine), undergoing chemotherapy. She is hospitalized for neutropenic fever; her hospital course has been unremarkable.

Her albumin is 2.7g/dl, calcium is 10.4mg/dl, and LDH 700IU/L.

She has a poor appetite and has lost 5 kilos in the last 2 months. She has been getting steadily weaker and now needs assistance with housework, and occasionally needs help getting up from a chair/toilet.

She understands her cancer is incurable, and asks you how much time you think she has to live. She tells you her oncologist told her 'It was in God's hands.'

The best initial response is:

a) I am God: 63 days.
b) I can't understand why all these oncologists never tell their patients the truth!
c) Most likely 1-3 months
d) Most likely 4-6 months

Question HPM38

JMs. L is a 46 year old who is currently receiving treatment for metastatic breast cancer. She has 3 children ages 8-13. Ms. L comes to your office complaining of fatigue. She states that she wants to participate more with her children's lives but symptoms of fatigue limit what she can do. She denies difficulty initiating or maintaining sleep. At times she is tearful but there are activities, such as watching movies with her children, that bring her joy. She denies worthlessness or excessive guilt.

Which of the following has the best evidence to improve her symptoms?

a) Structured Exercise program
b) Paroxetine
c) Limit energy expenditures
d) Megestrol

Question HPM39

Mr A is a 67 year-old Spanish-speaking man with metastatic pancreatic cancer diagnosed during this hospital stay. The physician on the palliative care team, Dr. S is organizing a family meeting to discuss prognosis and goals of care. The meeting is to include Mr. A and his son, the oncology team, and the social worker on the palliative care team.

Mr A speaks only Spanish. His son speaks both English and Spanish, as does Dr. S. The son says that he has been been acting as the interpreter during previous meetings with physicians.

The best next step would be:

a) Use a professional interpreter, but Dr. S should avoid short phrases in English as they often don't give enough context to give an accurate interpretation
b) Mr. A's son should act as the interpreter if it is ok with Mr A
c) Dr. S should conduct the family meeting in Spanish
d) Use a professional interpreter but ensure that the he/she is briefed before the family meeting

Question HPM40

You are called to see a 13 year old for a palliative care consultation. You call the pediatric oncologist who tells you the boy has had sarcoma for 4 years, and since he has been hospitalized for the latest round of cancer treatment the pain has become much worse. The oncologist shares that recent scans show the latest treatment is not working and there are no further measures he would offer, but he is not sure if he will discuss this with the patient himself. The parents know, and have been asking for increased pain medication, but the attending is concerned they are trying to "you know…move things along."

The best initial response to his concern is:

a) "It is a myth that opioids hasten death at the end of life"
b) "They probably are trying to protect him from finding out what is going on"
c) "Thoughts of hastening a child's death are not uncommon in these circumstances, but it's usually because of uncontrolled pain."
d) *"If you tell the patient the truth, the parent's grief will be diminished."*

Question HPM41

Your hospital ethics committee asks you to weigh in on a challenging case in the emergency room: a 3 month old baby, Marisol, with anencephaly has been brought to your publically-funded hospital from a private hospital. The baby is clearly having difficulty breathing and the mother (who has sole custody) is requesting that her baby be intubated for ventilatory support. "They wouldn't do it at Hospital Private, but told me you had to. After all, only God should determine when a baby dies - not you, nor I."

The pediatrician and neurologist both reinforce that with or without a ventilator, "it is a matter of time" before the baby dies. "Intubation seems to us medically inappropriate," they state. "We will do the right thing, morally and legally. We will take your advice."

What is your hospital's legal obligation in this case?

a) Baby Marisol must be intubated, and should move to establish a court-appointed guardian.
b) Baby Marisol should not be intubated, instead the focus should be on comfort at end-of-life.
c) Baby Marisol should not be intubated, and move to establish a court-appointed guardian.