What are refractory symptoms?
Refractory symptoms are considered symptoms for which all possible treatments have failed. A patient experiencing refractory symptoms must be differentiated from a patient who has symptoms that are difficult to treat. Refractory symptoms are symptoms that the palliative care physician and team determine cannot safely be relieved by invasive or non-invasive interventions. Expert panel members recommend Cherny’s definition of refractory symptoms: “Refractory symptoms are symptoms for which all possible treatment has failed, or it is estimated that no other therapies exist within the patient’s time-frame or tolerable risk-benefit ratio.”

When is PST considered?
PST is considered for patients with refractory symptoms only after discussions with the patient and/or family, the caregiving team, and the palliative care expert. The most frequent reasons for PST have been refractory delirium or restlessness, dyspnea, pain, and nausea/vomiting. The use of PST or psychological or existential distress is rare, and initiated only under exceptional circumstances.

PST is considered only in the last hours to days of life.

Experts recommend a systematic and inclusive process to determine if PST appropriate, which includes the patient, if possible, designated surrogate and caregivers, and addresses the patient’s values, beliefs, and goals. If PST is chosen, then the specific intervention is discussed and reviewed, instituted, and carefully monitored. Decisions about nutrition and hydration are discussed separately from the decision to offer PST.

Medications used for PST include benzodiazepines (usually midazolam), except for delirious patients, phenobarbital, or propofol. Opioids are not recommended for PST because even high doses may not result in sedation.

Since the aim of PST is the relief of refractory symptoms, doses of sedatives are carefully chosen to relieve distress by reducing a patient’s level of consciousness and are not excessive. The degree of sedation can vary from superficial to deep sedation. Initial doses of sedatives should be small enough to allow a patient to communicate periodically.
Refractory symptoms may respond to temporary sedation, since a patient’s ability to tolerate symptoms may be improved following rest provided by sedation. Experts identify three levels of continuous sedation. With mild sedation, the patient is awake, but has a lowered level of consciousness. Moderate sedation results in stupor, so that the patient is asleep, but can be awakened to communicate briefly. With deep PST, the patient is unconscious and unresponsive. PST is frequently monitored and assessed, with attention to the needs and goals of both patient and family.

Back to the case:
You convene a meeting with the patient, her family, and the palliative care team. After asking open-ended questions and listening to concerns, you offer information about PST but say that you think her symptoms can be treated. You offer medication changes including around-the-clock rather than as needed opioids for relief of dyspnea and pain, and a comprehensive treatment plan for her anxiety and depression. Her family finds ways for her to be less isolated, and the hospice team offers additional services and frequent monitoring. Although she is skeptical, she is willing to consider these options as possibly improving the quality of her life.

References: