

PALLIATIVE CARE IN ONCONEPHROLOGY

SYMPTOM MANAGEMENT AND DECISION SUPPORT

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SEPTEMBER 17, 2026



OBJECTIVES

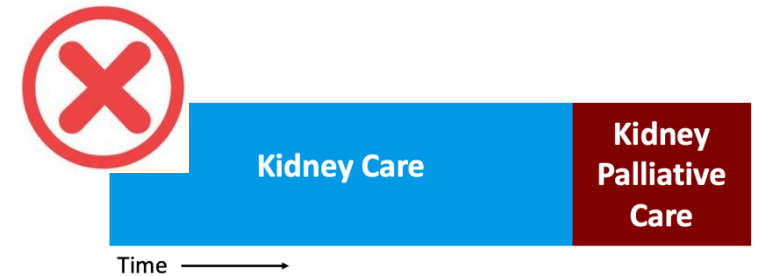
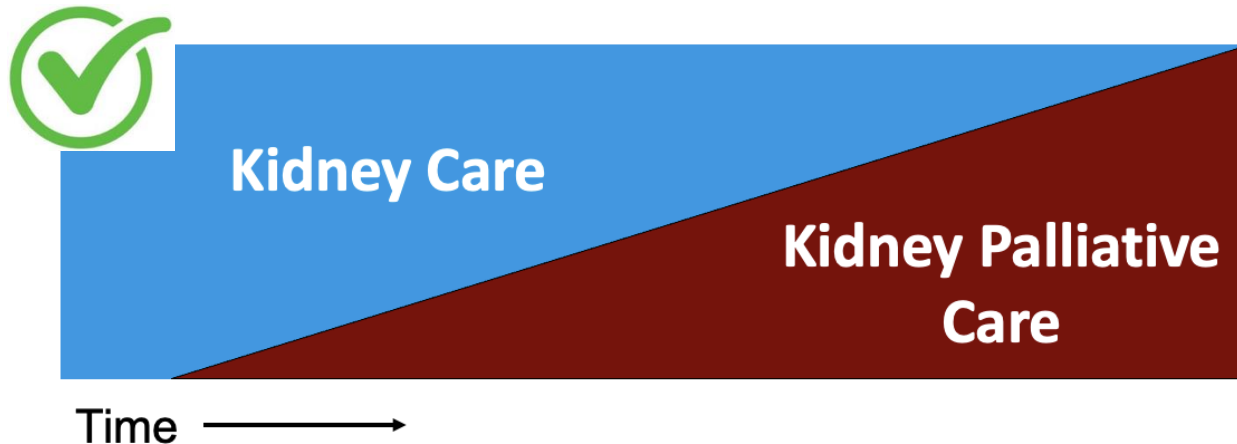
- Review symptom management strategies for onconeurology patients
- Explore an approach to complex decision-making for onconeurology patients

DISCLOSURE

- I have no conflicts of interest related to this presentation.

Kidney Palliative Care

- Live as well as possible with advanced kidney disease
- Manage symptoms and navigate complex decisions
- Any age, any treatment modality



Palliative Care for Patients with Cancer and Kidney Disease



Patients with cancer and kidney disease have high symptom burden

Kidney failure confers a similar symptom burden as metastatic cancer.

Living with both compounds morbidity and mortality.

Palliative care practices should be adjusted for kidney disease

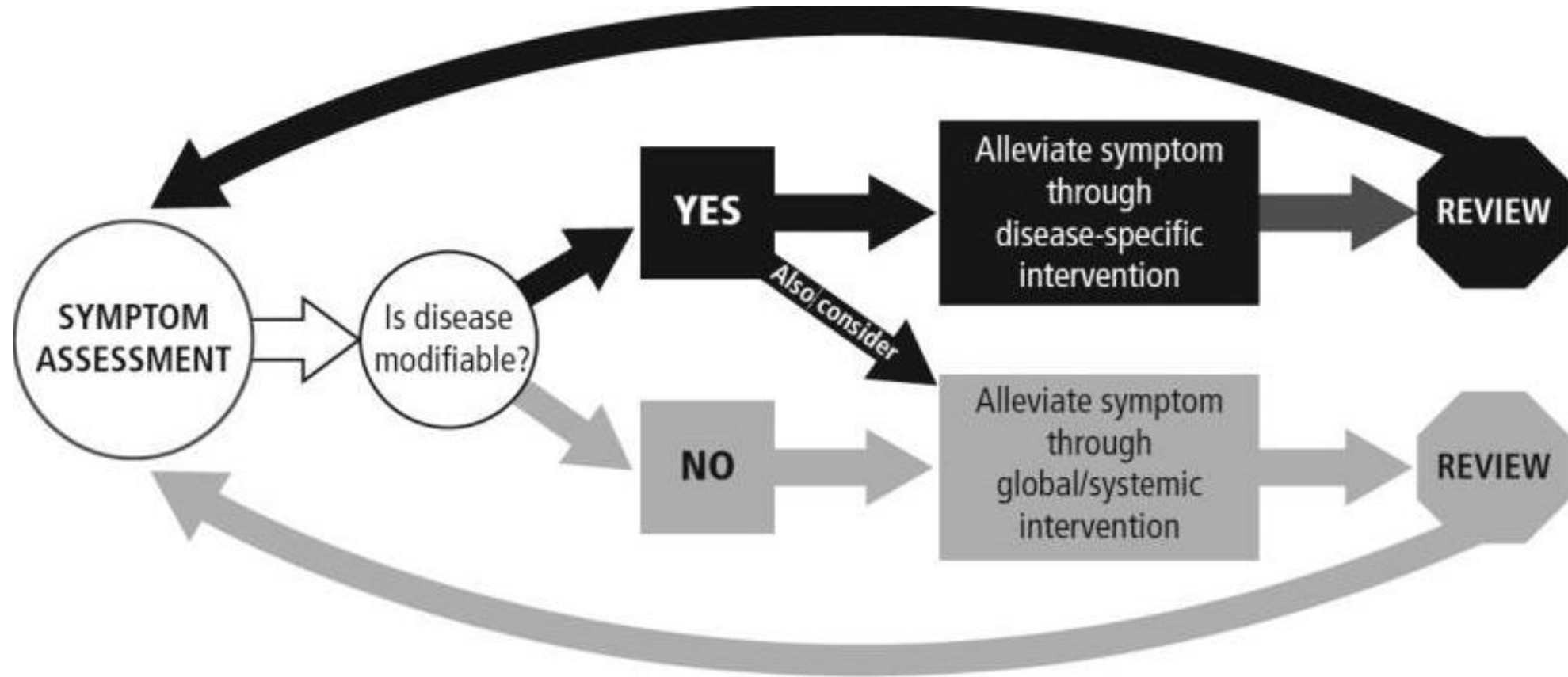
- First-line medication agent selection
- Dose adjustments based on eGFRcreatinine-cystatin c
- Consideration of medication active metabolites/route of elimination

Reference: Corona et al. ACKD. 2022
VA by Sharanya Ramesh, MD, PhD.

 @SRameshMD

Conclusion: Pharmacologic management of symptoms in patients with cancer and kidney disease requires recognition of the type of pain, its cause, and the risks and benefits of different medication classes.

PALLIATION OCCURS VIA DISEASE MODIFICATION **AND** DIRECT SYMPTOM TARGETING



NOCICEPTIVE PAIN

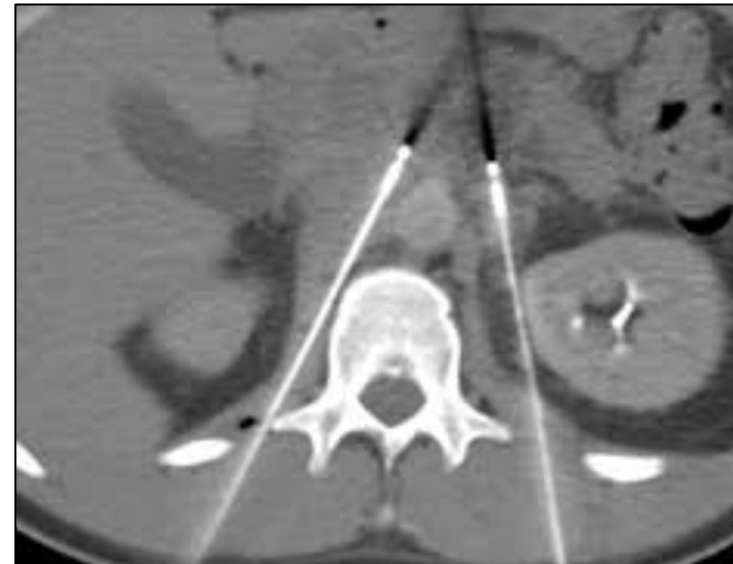
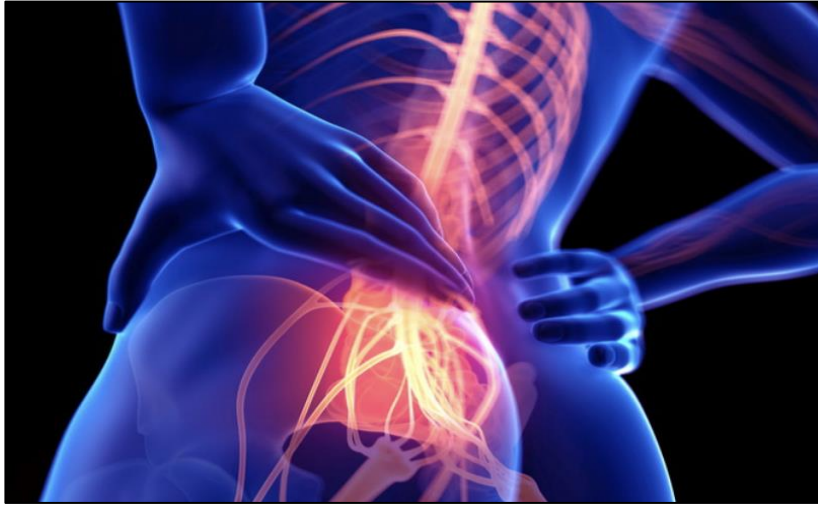


Nociceptive somatic



Nociceptive visceral

NEUROPATHIC PAIN



(celiac plexus block)

METABOLITES INFLUENCE OPIOIDS' SAFETY PROFILE IN CKD

Natural Opioids (opium-derived)

Morphine, Codeine

Morphine-3-Glucuronide

Cleared by kidney, active

Morphine-6-Glucuronide

Cleared by kidney, active (potent analgesic)

Synthetic Opioids

Hydrocodone

Norhydrocodone, hydromorphone

Cleared by kidney, active

Oxycodone

Noroxycodone, noroxymorphone

Cleared by kidney, active

Hydromorphone

Hydromorphone-6-Glucoronide

Cleared by kidney (inactive / inert)

Fentanyl

Norfentanyl

Cleared by kidney (inactive / inert)

Methadone

EDDP, EMDP

Cleared by liver / feces

Buprenorphine

Norbuprenorphine

Cleared by liver / feces

Most effective for
neuropathic pain



Combination Opioids

Tramadol

(+) enantiomer metabolized to opioid (M1)

Cleared by kidney, active

(-) enantiomer metabolized to SNRI

M1 is potent analgesic

NEUROPATHIC PAIN IS ALSO COMMON IN CANCER AND CKD

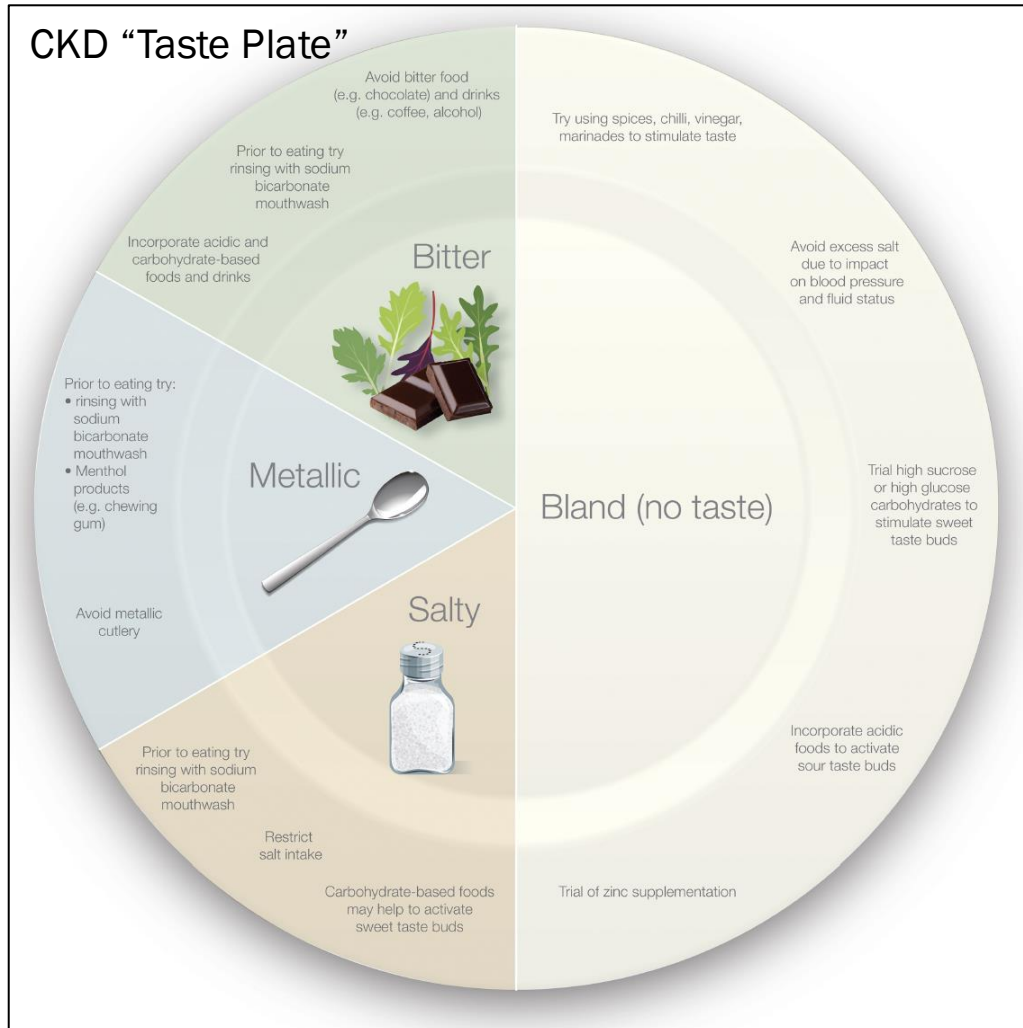
Table 3. Treatments for Neuropathy in Patients With Kidney Disease

Class	Agents	Starting Doses	Most Common Adverse Effects
Calcium channel alpha-2-delta ligands ^a	Gabapentin Pregabalin	Gabapentin: 100 mg daily at night (if on dialysis, reduce to 100 mg 3×/wk after dialysis) Pregabalin: 25 mg daily at night (if on dialysis, reduce to 25 mg 3×/wk after dialysis)	Dizziness, drowsiness, edema, ataxia
Serotonin-norepinephrine reuptake inhibitors	Duloxetine Venlafaxine (extended release) Tramadol	Duloxetine: 30 mg daily (if on dialysis, avoid) Venlafaxine: 37.5 mg daily Tramadol: 50 mg every 8-12 h	Headache, drowsiness, dry mouth, nausea, insomnia, withdrawal syndromes
Tricyclic antidepressants	Amitriptyline	10 mg daily at night	Dry mouth, urinary retention, blurred vision, change in libido, dizziness, weight gain, insomnia
Voltage-gated sodium channel blockers	Lidocaine ^b Mexiletene ^b	Lidocaine: weight-based Mexiletene: 150 mg 1-2×/d	Dizziness, ataxia, nervousness, tremor, arrhythmia
Opioids	Methadone ^b	2.5 mg every 8-12 h	Constipation, weight gain, delirium, sexual dysfunction, prolonged QTc
Topical agents	Lidocaine patch Capsaicin	Lidocaine: 1 patch every 12 h; can wear up to 3 patches at a single time Capsaicin: 0.025% ointment, compounded with menthol when available	Numbness (lidocaine), burning (capsaicin)

^aCaution and close monitoring are recommended with any off-label use of calcium channel alpha-2-delta ligands.

^bReferral recommended to pain management specialist.

TASTE CHANGE (DYSGEUSIA) IS COMMON IN CANCER THERAPY AND CKD



Dana-Farber
Cancer Institute

Leonard P. Zakim Center
for Integrative Therapies
and Healthy Living

Videos

[What to Eat When You Experience Taste Changes During Cancer Treatment](#)

Jan 17, 2024

[What to Eat When You Have Nausea During Cancer Treatment](#)

Apr 7, 2023

[What to Eat When You Have Diarrhea During Cancer Treatment](#)

Apr 7, 2023

[What to Eat When You Don't Have an Appetite During Cancer Treatment](#)

Apr 7, 2023

WHAT IS THE “RIGHT” THING TO DO?

An 88-year-old woman with CKD stage 4-5 (eGFR 15) attributed to DM and HTN, prior breast cancer (2021), AF/SSS s/p PPM (2021), and recurrent DVT s/p IVC filter is diagnosed with ovarian cancer via omental biopsy (FIGO Stage IIIC (cT3c, cN0, cM0, Stage IIIC). She was referred to kidney clinic for outpatient goals of care (GOC) discussion about potentially kidney failure treatment options.

ECOG-1



IS DIALYSIS WITHIN HER GOALS OF CARE?

Questions we ask the patient and their healthcare proxy:

What is your understanding of your cancer and your kidney disease?

How do you expect chemotherapy to go, including how long you might live and likely side effects?

What have you heard about dialysis?

If time were short, what sorts of things would matter most to you?

What are you hoping for?

What are you worried about?

What makes for a good day / good quality of life for you?

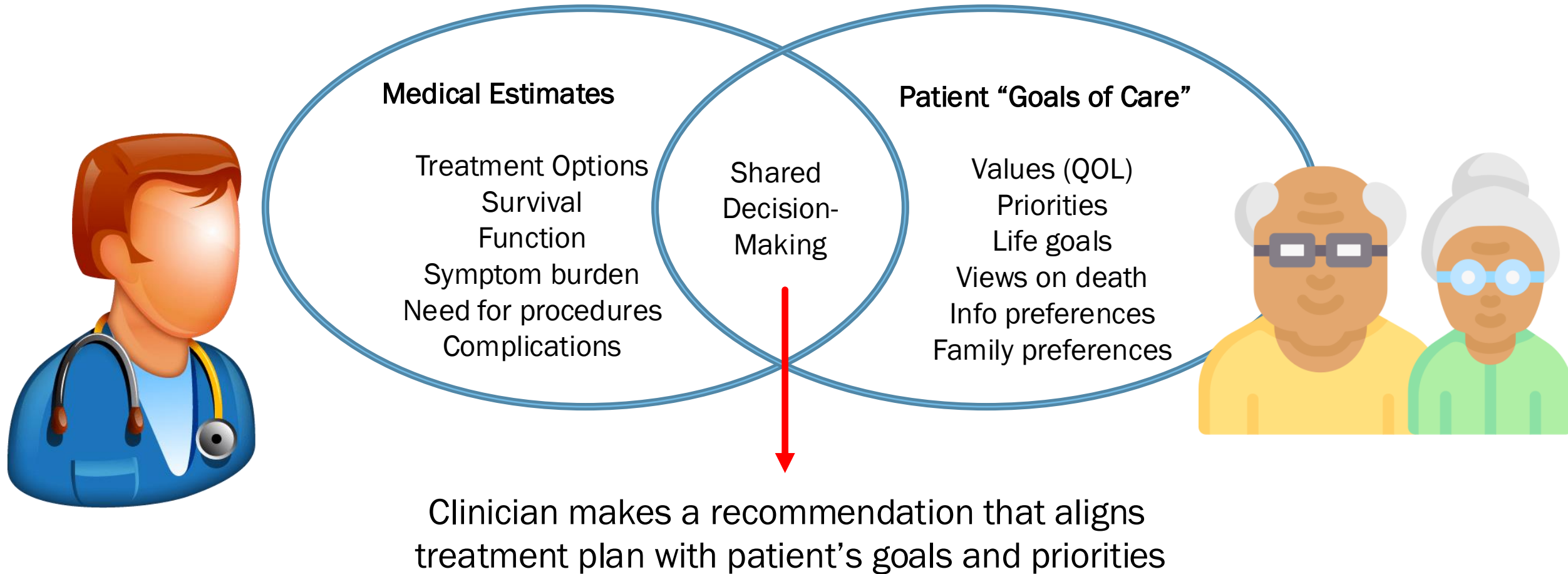
Are there any treatments or ways of living that would be unacceptable to you?

How have you approached big health decisions in the past?

Do you expect your physicians to make the decision or provide you with information / you make the decisions?

Has anyone in your life been seriously ill before? How does that impact your thoughts on your own care?

SHARED DECISION-MAKING IN ONCONEPHROLOGY



Serious Illness Conversation

Flowsheet Row	Office Visit from [REDACTED] in Brigham and Women's KidneyPal Program
<u>Serious Illness Conversation</u>	
DATE	[REDACTED]
DOCUMENTED BY	Sam Gelfand
CONVERSATION HELD WITH CAREGIVER	Patient, Caregiver/Family/Support Person Daughter
UNDERSTANDING HEALTH	She knows she has ovarian cancer and treatment may cause kidney failure. She understands she is not considered to be a surgical candidate, but that with medical therapy, her prognosis may be over a year (and she mentioned some stat about 5 years).
IMPORTANT TO PATIENT/FAMILY/CAREGIVER	It feels important to Violet to live as long as possible and to try treatment. Their experience of ageism in VA (nephrology) also catalyzes their advocacy / interest in trying therapy and seeing how it goes rather than assuming she is too old to do well. She would like to stay active in activities at her assisted living, active in her faith / bible group, and ideally go to a grandchild's wedding in May 2027 if she can. She feels "all avenues are open in God".
CONCERNS/WORRIES	She could not name a worry currently other than treatment being withheld due to her age. She does not feel she is suffering currently, and she feels secure in her faith that whatever happens is God's will. She did reflect that she worries about a death with suffering and would prefer to go peacefully / in her sleep if possible, and shared a bit about the end of life experiences of two of her closest friends (one positive, one negative involving a family needing to discontinue life support). This led her to opt for DNR/DNI.
RECOMMENDATIONS/NEXT STEPS	Close follow up with oncology, DFCI palliative, and nephrology

CONDITIONS FOR NOT INITIATING DIALYSIS



Shared Decision-Making in the
Appropriate Initiation of and Withdrawal
from Dialysis, Second Edition, 2010

Recommendation 5

- Patients with capacity who refuse dialysis
- Patients without capacity who refused dialysis in the past (verbally or with advance directive)
- Patients without capacity whose surrogate decision-maker refuses dialysis
- Patients with irreversible profound neurological impairment

Recommendation 6

- Patients who cannot cooperate with or tolerate dialysis
- **Patients who have a terminal illness from non-renal causes** (acknowledging that some may perceive benefit and choose to undergo dialysis)
- Patients with CKD 5, age > 75, and two or more statistically significant poor prognosis criteria

LIVING LONGER IS **NOT** THE MOST COMMON **TOP PRIORITY** OF OLDER ADULTS WITH ADVANCED CKD

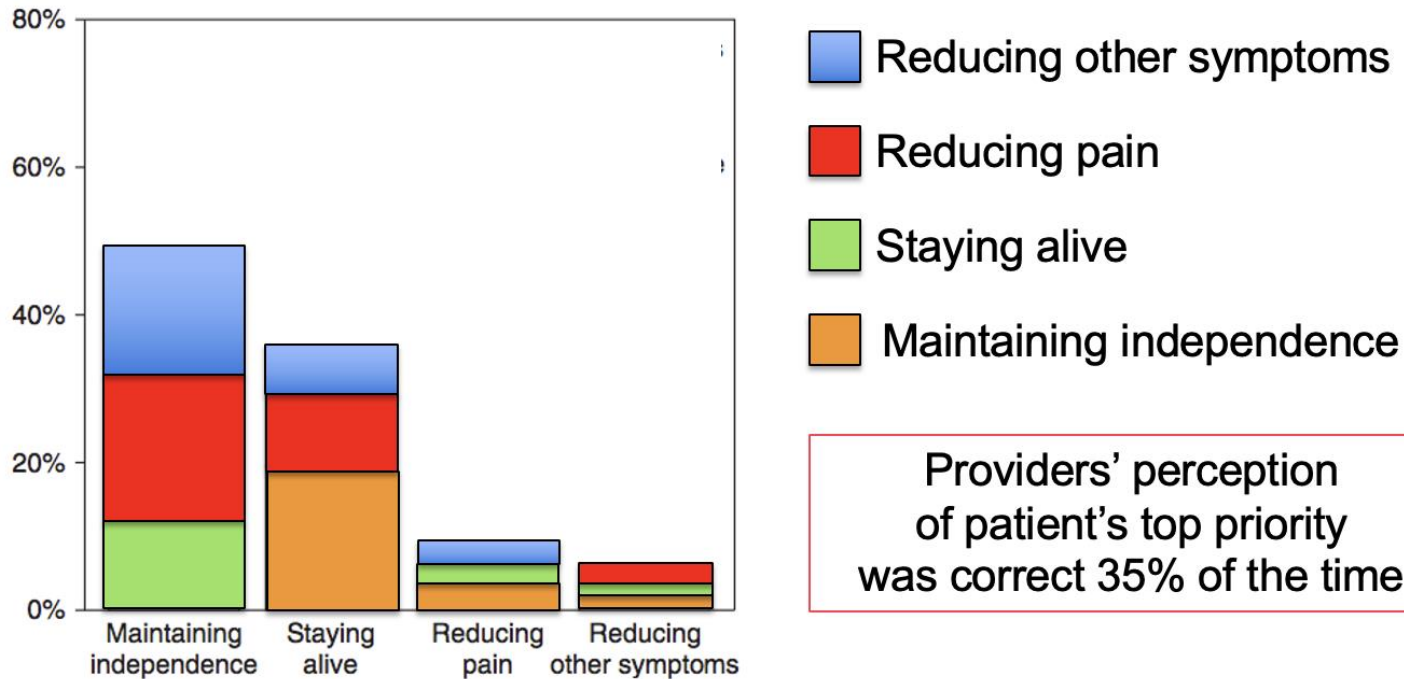
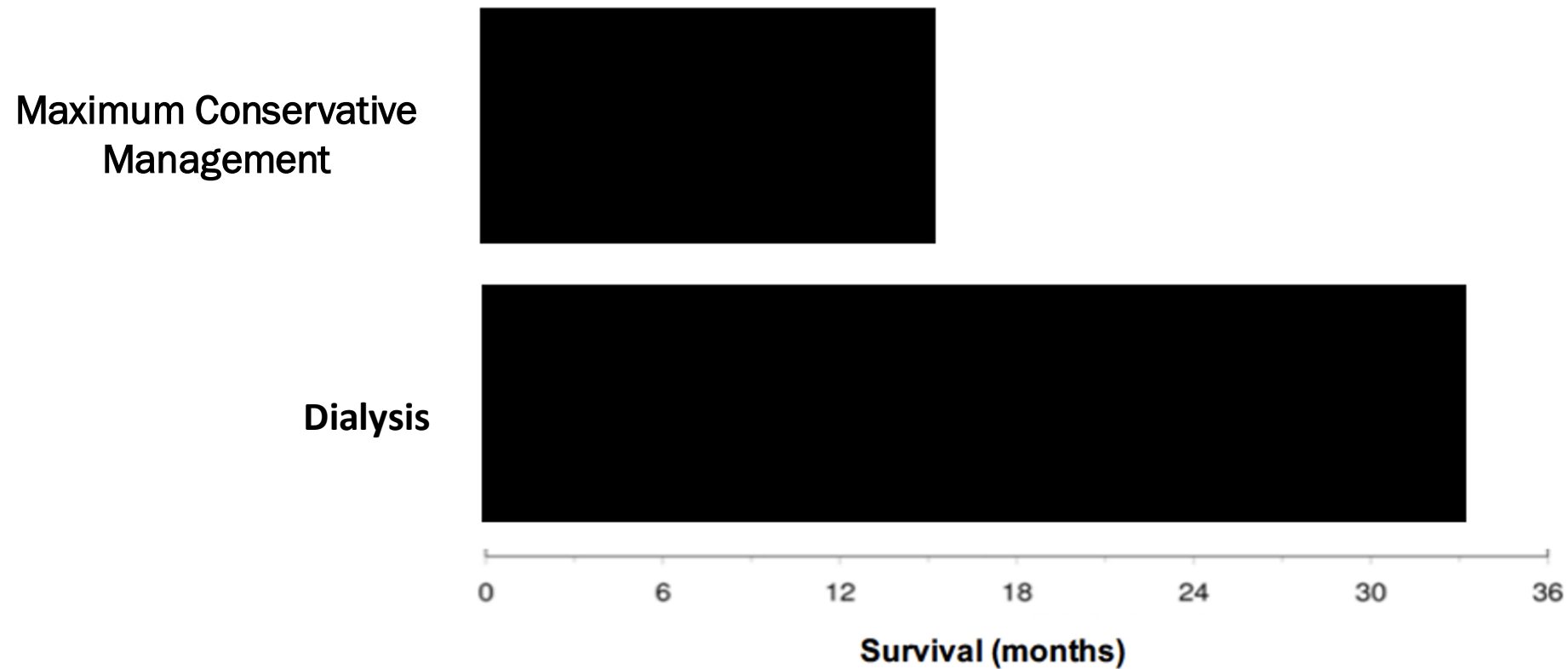


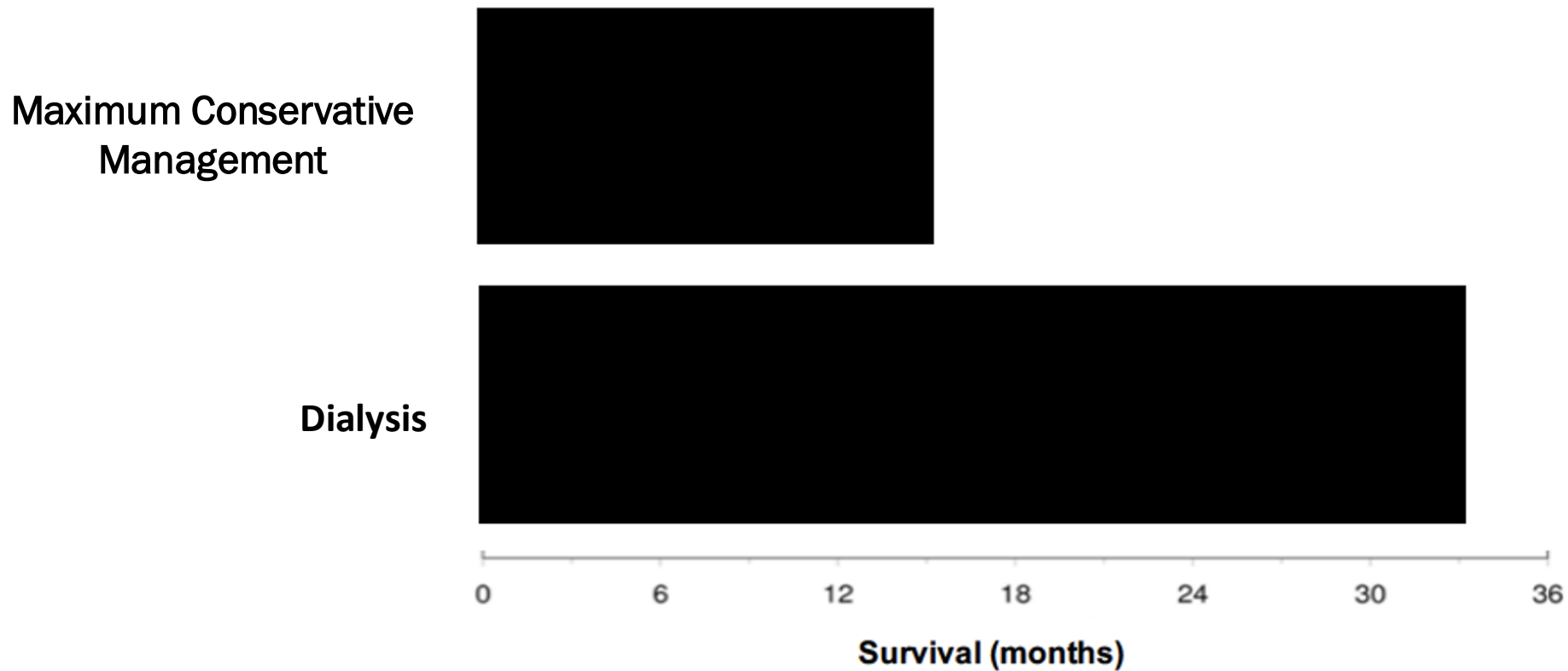
Figure 1. Patients' first and second choices for health outcome priorities. The proportion of patients who designated a particular outcome as first priority is displayed as a main bar; the proportion of those patients who designated a particular outcome as second priority is displayed as a sub-bar.

HELP PATIENTS APPRECIATE THE TIME TOXICITY OF DIFFERENT THERAPIES



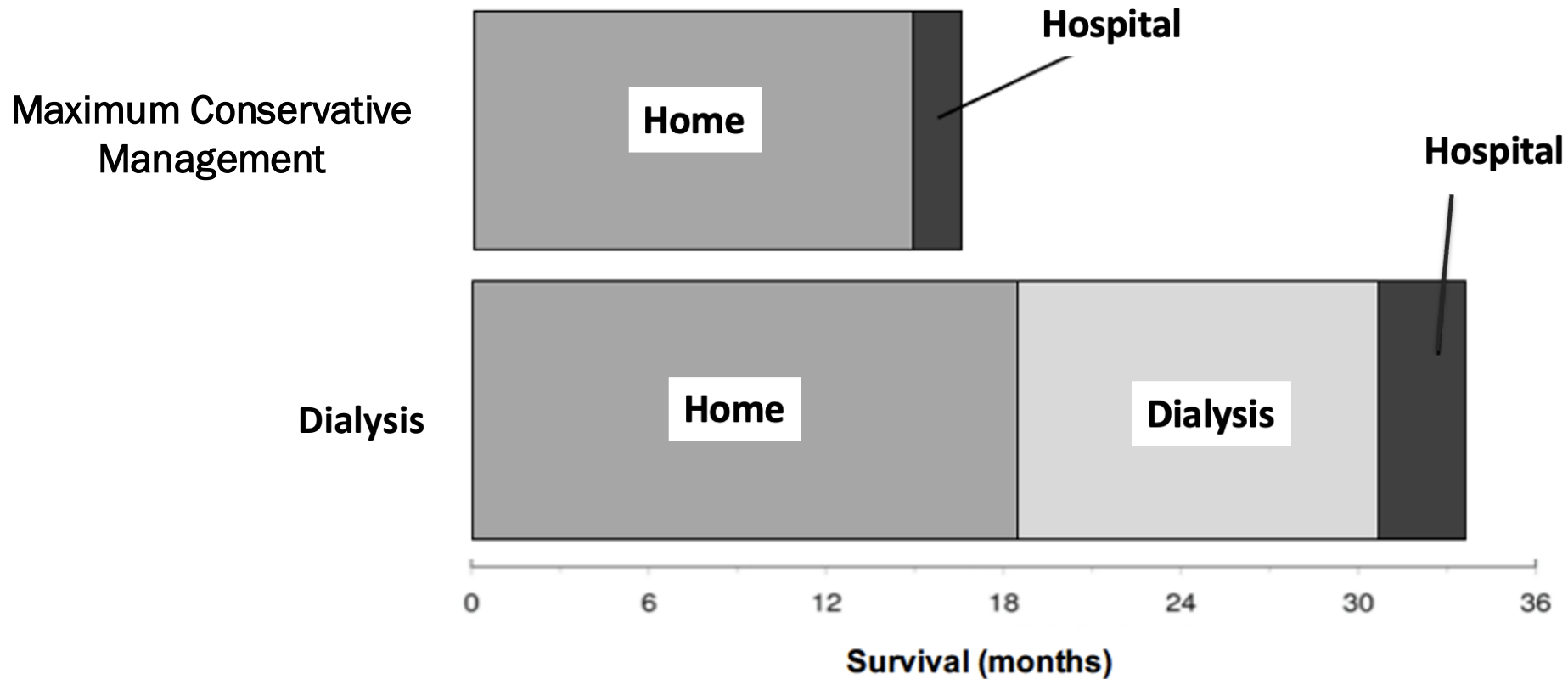
HELP PATIENTS APPRECIATE THE TIME TOXICITY OF DIFFERENT THERAPIES

HOW IS THE ADDED TIME SPENT?



HELP PATIENTS APPRECIATE THE TIME TOXICITY OF DIFFERENT THERAPIES

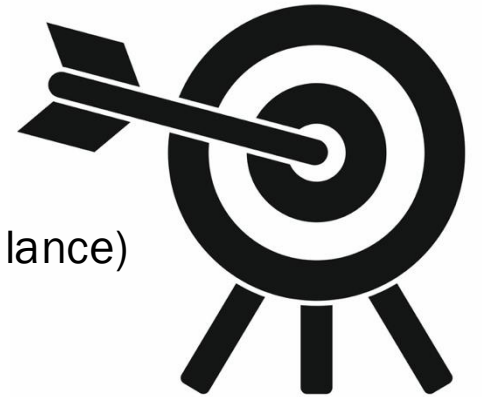
HOW IS THE ADDED TIME SPENT?



PILOTS OF CONCURRENT DIALYSIS + HOSPICE ARE UNDERWAY

“Palliative” dialysis

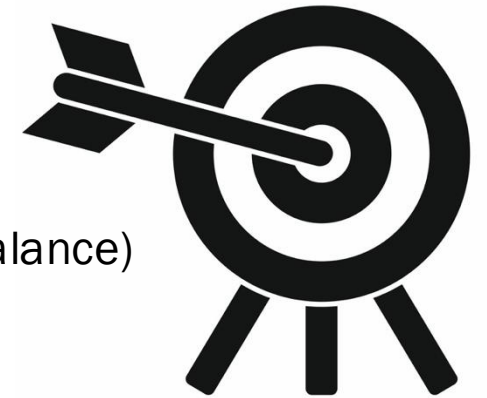
- Tailored to individual patients’ needs (e.g. 2x/week instead of 3x/week)
- Divergence from typical quality metrics (e.g. less focus on AV fistulas and phosphate balance)



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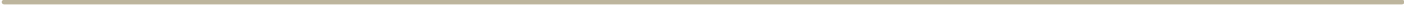


Pilot study of concurrent hospice + dialysis (UPMC)

- N = 43 over 3 years, mean age = 74 years
- Program allowed up to 10 HD treatments or 1 month of PD after hospice enrollment
- Mean 3.5 HD sessions / 19 days of PD; 23 patients did not want further dialysis after hospice enrollment
- 2 patients hospitalized, none died in hospital, majority died at home



CONCLUSIONS



Cancer, kidney disease, and their therapies all confer significant symptom burden, which can be addressed directly as well as through disease modification.

Shared decision-making is an iterative process that should include the nephrologist, oncologist, patient, and loved ones working toward choosing a therapy plan best aligned with the patient's preferences and prognosis.