Pallium Canada

Palliative Care Journal Watch

A partnership between Pallium Canada and several Divisions of Palliative Care and Medicine across Canada and Internationally: University of Calgary, University of Alberta, Queens University, Hadassah-Hebrew University Medical Center, University of Navarra

Hosts and Panelists

Dr. Jose Pereira and Dr. Leonie Herx

January 19, 2026

Welcome to the Palliative Care Journal Watch!

- Keeps you up to date on the latest peer-reviewed palliative care literature.
- Led by palliative care experts from several divisions of palliative care/medicine across Canada and internationally.
  - University of Calgary
  - University of Alberta
  - Queen's University
  - Hadassah-Hebrew University Medical Center, Israel
  - University of Navarra, Spain
- With the assistance of the Pallium Canada team
- We regularly monitor over 30 journals and highlight articles that challenge us to think differently about a topic or confirm our current practices.

Introductions

Dr. José Pereira, MBChB, CCFP(PC), MSc, FCFP, PhD

Professor, Faculty of Medicine, and Institute for Culture and Society, University of Navarra, Spain.

Scientific Advisor and Co-Founder, Pallium Canada

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Disclosures

Pallium Canada

- Pallium is a registered charity.
- Pallium generates funds to support operations and R&D from course registration and registration fees, sales of the Pallium Pocketbook sales, and philanthropy.

Mitigating Potential Biases

- The curriculum team and scientific planning committee had complete independent control over the development of course content.

Disclosures of Hosts/Guest Panelists

No conflicts of interest to disclose

- Dr. José Pereira
- Dr. Leonie Herx

Featured Articles

1. Tate DH, Ferguson DL. **Subcutaneous Dexmedetomidine for Refractory Symptoms in a Hospice Inpatient Unit.** J Pain Symptom Manage. Published online October 28, 2025:S0885-3924(25)00903-0. Doi:10.1016/j.jpainsymman.2025.10.014
2. Thomas B, Barclay G, Mansfield K, Mullan J, Lo WSA. **Dexmedetomidine Versus Midazolam for End-of-Life Sedation: The DREAMS Non-Blinded Randomized Clinical Trial.** J Pain Symptom Manage. 2025;70(5):459-469. doi:10.1016/j.jpainsymman.2025.07.027
3. Nolen A, Selby D, Qureshi F, Mills A. **Practices of and Perspectives on Palliative Sedation Among Palliative Care Physicians in Ontario, Canada: A Mixed-Methods Study.** Palliative Medicine Reports. 2024;5(1):94-103. Doi:10.1089/pmr.2023.0081
4. Arias-Rojas M, Arredondo-Holguín E, Carreño-Moreno S. **Efficacy of the "PalliActive Caregivers" intervention for caregivers of patients with cancer in palliative care**. BMC Palliative Care. 2025;24(1):235. doi:10.1186/s12904-025-01885-1

Featured Articles

Subcutaneous Dexmedetomidine for Refractory Symptoms in a Hospice Inpatient Unit

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Dexmedetomidine Versus Midazolam for End-of-Life Sedation: The DREAMS Non-Blinded Randomized Clinical Trial.

Article Reference: Thomas B, Barclay G, Mansfield K, Mullan J, Lo WSA. Dexmedetomidine Versus Midazolam for End-of-Life Sedation: The DREAMS Non-Blinded Randomized Clinical Trial. J Pain Symptom Manage. 2025;70(5):459-469. doi:10.1016/j.jpainsymman.2025.07.027

Selected and Presented by:

Dr. Leonie Herx

Background - Dexmedetomidine

- Delirium & distress are common at end of life (EOL)
- Sedative medications (e.g. benzodiazepines) used to manage symptoms can diminish interactions
- Alpha-2 agonist dexmedetomidine beneficial in treating delirium in ICU while allowing enhanced interactivity.
- DXM shown to provide relief of agitation, pain and dyspnea, opioid-sparing, and does not cause resp depression
- 90% bioavailable as SC infusion vs IV (20 vs 10 hrs to steady state respectively), less sympatholytic effects SC – hypotension and bradycardia uncommon
- Palliative care (PC) use increasing interest for refractory symptoms requiring sedative medications without deep sedation.
- Limited data describing use in palliative care - single arm trials with no comparators, no RCTs

Tate DH, Ferguson DL.

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Research Question

- To assess the safety and effectiveness of DXM given via subcutaneous infusion in palliative care unit using descriptive analysis of patient demographics, treatment characteristics, effectiveness and safety factors

Methods

- Retrospective observational review of clinical records from single centre in New Zealand
- Inclusion criteria: age 18+ received DXM CSCI, October 2019 to February 2024
- DXM discontinued >24hrs then restarted, counted as separate
- Dosing: 0.2-0.4 mcg/kg
- Patients received any other medications for symptom management deemed appropriate by attending physician
- Data collected: patient characteristics; DXM dosing/duration; adverse events; effectiveness via RASS-PAL at baseline/6hr/24hrs, charting, changes in opioid/midaz infusions at 24 & 48 hrs after starting DXM and need for CPST.
- 29 patients met inclusion criteria, 4 excluded due to another DXM trial, 25 unique patients & 26 infusion events included

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Key Results

- Demographics:
  - 907 PCU admissions (sx mx/EOL), DXM used in 25 pts (3%), 26 events
  - 24/25 died in PCU, 23/24 continued DXM until death
  - Indications: refractory pain (92%), agitated delirium (50%), mean 1.5/pt
- DXM CSCI characteristics:
  - Median CSCI duration 4 days
  - Reason for discontinuation: death (88%), improved pain control (8%), establishment of epidural analgesia (4%)
  - Other symptom management meds: median 2.5 at initiation DXM
  - DXM CSCI started at 0.2 mcg/kg/hr (5 pts severe sx started at 4 mcg/kg/hr, 2 pts frailty started at 0.1 mcg/kg/hr). Uptitration to max rate 1.4 mcg/kg/hr)
  - Max rate reached by 5 pts (25%), 2 pts did not require titration (<10%)
  - Clinician boluses 0.2-0.4 mcg/kg used prior to care or for increased agitation
- Adverse Events:
  - No serious adverse events
  - Dry mouth (58%), possible opioid toxicity (31%), SC site concerns (23%)
  - 4 patients had signs of opioid toxicity resulting in decrease of opioids with improvement in RR and/or alertness
  - Unclear if AEs attributable to DXM

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- Effectiveness:
  - Median RASS-PAL: baseline +1, signif change from baseline -1.5 at 6hr, -2 at 24 hr. 1 pt experienced increase from baseline at 24hr (by +1).
  - Day 1: 88% DXM CSCI perceived effective by clinicians; 62% by patients/families 28% not captured; 12% perceived ineffective
  - 42% progressed to CPST after mean 4.6 days on DXM CSCI
  - 95% had reduction in opioid doses on day 1, 65% had further reduction on day 2

Key Discussion Points

- Data demonstrates safety and tolerability of DXM in hospice PCU setting.
  - SC site issues similar to other CSCI in pall care
- Opioid sparing effect – dose reduction seen in most patients in first 24 hours, and >50% further reduction or stabilization on day 2.
- Downward shift in RASS-PAL first 24hr significant – clinician perception correlates (but patient/family perspective missing in many cases)
- >40% progressed to CPST (after med 4.6 days) likely reflects refractory nature of sx requiring DXM (vs 11% of PCU admissions in 2023) or may suggest tachyphylaxis with prolonged use of DXM

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Strengths

- Largest retrospective analysis of DXM CSCI to date

Limitations

- Retrospective and observational design – unable to draw conclusions on effectiveness of DXM due to nature of clinical documentation (often using proxy measures) and no control/comparator group
- Single reviewer for data analysis, risk of bias

Impact on Practice

- DXM CSCI safe and well tolerated and perceived by clinicians as effective for refractory symptoms
- May offer an intermediary step before CPST for patients with difficult symptoms
- Further studies are needed, including prospective and RCTs and longer term trials (eg tachyphylaxis, dose titrations)

Thomas B, Barclay G, Mansfield K, Mullan J, Lo WSA.

Dexmedetomidine Versus Midazolam for End-of-Life Sedation: The DREAMS Non-Blinded Randomized Clinical Trial.

J Pain Symptom Manage. 2025;70(5):459-469.

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Research Question

- To compare sedative efficacy of subcutaneous dexmedetomidine (DXM) vs midazolam (MDZ) in managing distress at EOL
- Hypothesis: DXM would result in better rousability while maintaining comfort at end of life compared to MDZ

Methods

- Single centre non-blinded RCT of palliative care inpatients admitted for EOL care
- Randomized 1:1 at admission for EOL. Initiation of study meds: if refractory* symptoms & death expected within 7 days.
- Primary outcome: responsiveness measured by RASS-PAL first 72 hours
- Secondary outcomes: severity of delirium (MDAS) & comfort (PCA) RASS-PAL 3x/day, MDAS & PCA 1x/day. RASS-PAL & MDAS at baseline
- Subcut infusions: DXM 0.5 mcg/kg/hr, MDZ 0.25 mg/kg/24hr
- BT dose: DXM 0.5 mcg/kg, MDZ 2.5-5mg every2 hours PRN (max 5). High rescue use: 3+/day without other cause.
- Continue to treat other symptoms as usual

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Presented by:

Dr. Leonie Herx

Key Results

- 52 patients randomized May 2021 - Nov 2023, 26 DXM/26 MDZ arms
- Median age 80, 63% male, 92% cancer
- Median infusions: DXM 805 mcg/24 hr, MDZ 18mg/24 hr
- Primary outcome: no significant difference in mean RASS-PAL between arms, mean -2 to -3 (light to moderate sedation) but some below -3
- Secondary outcomes: MDAS & PCA improved in both
  - DXM arm - earlier lower delirium severity scores (MDAS)
  - No difference in PCA between arms, DXM significant improved comfort day 3 from 2.
- Protocol withdrawal similar but earlier in MDZ arm

Key Discussion Points

- Neither DXM or MDZ superior for responsiveness in first 72 hours
- Delirium severity improved in both with DXM superior in 1st 24 hr, ?tolerance to DXM requiring dose titration as seen previously
- Patient comfort similar between arms
- Lack of dose escalations may have led to earlier protocol withdrawals
- Faster rate of protocol withdrawal in MDZ arm – staff documentation described discomfort at time of withdrawal from MDZ arm. May develop tolerance and require higher doses

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Strengths

- Randomized trial in end of life context

Limitations

- Small sample size (attrition due to death and protocol withdrawals)
- Single dose protocol does not reflect clinical practice standards
- RASS-PAL averaged daily scores, ?adequacy for assessing continuous variable like consciousness
- PCA not assessed at baseline
- Refractory distress diagnosed by clinical judgement & could lead to selection bias
- Primarily cancer patients ? generalizability

Impact on Practice

- Not enough information to draw any conclusions

Discussion

Nolen A, Selby D, Qureshi F, Mills A.

Practices of and Perspectives on Palliative Sedation Among Palliative Care Physicians in Ontario, Canada: A Mixed-Methods Study.

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Selected and Presented by:

Dr. Jose Pereira

Background

- Palliative sedation (PS) is a therapeutic intervention for the management of **severe** and **refractory** symptoms at **EOL**.
- Inconsistencies in PS practice guidelines coupled with "clinician ambiguity" have resulted in confusion about PS best practices.

Research Question

- To explore the perspectives of palliative care physicians administering PS, including how practitioners define PS, factors influencing decision making about the use of PS, and possible reasons for changes in practice patterns over time.

Methods

- Exploratory, mixed method sequential study:
  - Survey (n=37) followed by semi-structured interviews (n=23)
  - Palliative care physicians in Ontario, Canada
  - March-May 2022
- Participants: Recruited via OMA Palliative Care Section list. At least 5 years of independent practice.
- Quant analysis: Descriptive statistics
- Qual: Thematic descriptive analysis

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Selected and Presented by:

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Key Results

- **Survey** (n=37 respondents):
  - Working in palliative care: 42% 5-10yrs; 26% 11-20yrs, 29% 21-30 yrs)
  - Site of practice: academic centre (n=26), Community (n=15)
  - Types of services: Home (n=17), outpatient (n=18), inpatient consults (n=21), PCU/hospices (n=23)
  - % of pts PS initiated on: 1-10% (73%); 11-20% (18%); 21-30% (6%)
  - Indications for use of PS: Delirium (n=33); dyspnea (n=26) ; pain (n=16); existential distress (n=15); other (n=6)

- **Interviews** (n=23 participants)
  - Years working in palliative care: mean 12.5 (5-39)
  - Location of practice: home (9), outpatient clinic (7), inpatient consult (12), PCU or hospice unit (9)
- **Qual themes**
  - Lack of standardization in practice (variability in frequency of use, lack of standardized eligibility criteria and practice protocols)
  - Differing definitions: PS as secondary effect of symptom control; defined by intent and outcomes; being done without labelling it as such
  - Logistical challenges (lack of familiarity with PS; community practice)
  - Perceived backup to MAID; Loss of distinction between MAID and PS
  - Depends on who is MRP

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Key Discussion Points

- Lack of uniformity and inconsistencies in PS practices: frequency, definition, timing, application.
- Variations in terminology: e.g. “intermittent” (or respite) sedation versus continuous sedation, proportionate/“gradual” sedation versus continuous deep sedation, “rapid” induction of unconsciousness.
- Disagreement over the use of medications with sedating side effects (delirium).
- Prevalence of PS varies widely across care settings and jurisdictions.
- Local guidelines can result in improvements to clinical practice.
    - But inconsistencies with respect to recommendations about timing of initiation of PS, medication protocols, and approach to artificial nutrition and hydration

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Strengths

- Mixed methods approach
- Good description of qual analysis process

Limitations

- Restricted to Ontario (so variations may exist across provinces and across regions)
- Does not describe how researchers ensured Reflexivity

Impact on Practice

- Need for greater educational resources and interventions on palliative sedation, particularly among inpatient interprofessional teams, where there was often confusion surrounding the nature and goals of PS.

Discussion

Arias-Rojas M, Arredondo-Holguín E, Carreño-Moreno S.

Efficacy of the "PalliActive Caregivers" intervention for caregivers of patients with cancer in palliative care.

BMC Palliative Care. 2025;24(1):235.

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Presented by:

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Background

- Caregivers undertake many different tasks.
- They seldom receive any preparation or training for this role.
- Lack of preparation and training increases their distress, burden and uncertainty.

Research Question

- Assess the efficacy of an education program called *PalliActive Caregivers* designed to educate caregivers of cancer patients on providing care, managing symptoms, and caring for themselves.

Methods

- Cancer Centre in Medellín, Colombia.
- RCT undertaken over 7 months (2022)
- Participants: Informal family caregivers of adult cancer patients (not at EOL)
- Excluded: Caregivers with prior caregiving experiences or training, hired caregivers, or non-Spanish speaking
- 1:1 randomization
- Participants and data collectors blinded

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Methods

- **Intervention group**: PalliaActive Caregivers course
- **Control group**: Usual care; "face-to-face" assistance and education by "general nurse with palliative care experience" prior to discharge. No other supports or resources provided.
- **Intervention**
  - 2-session face-to-face teaching: total 90 min.
  - Given by experienced palliative care nurse
  - Described in detail in the article
- **Outcome measures**:
  - Caregiver role: ROL (tool previously validated by same group)
  - Support: MOS Social Support Survey (self-reporting, previously validated for pts)
  - Caregiver's QOL: Quality of Life in Life-Threatening Situations Family Version (QOLLTI-F)
- **Data collected at:**
  - T1: Baseline
  - T2: 2 weeks post training
  - T3: 4 weeks post training
- **Sample size calculation:** 194 (to account for attrition)
- Analysis: repeated-measures ANOVA test and Effect Size

Efficacy of the "PalliActive Caregivers" intervention for caregivers of patients with cancer in palliative care.

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Key Results

- Completion rate
  - T1: 242 participants
  - T2: 115 (48%) (58 intervention, 57 control)
  - T3: 70 (29%) (33 intervention, 37 control).
- Participants
  - Both groups similar: mean age 44 yrs
  - 79% female, parents ~38%, partner/spouse ~24%, friends 23%
  - high school education 35%
- Patients:
  - Similar across both groups;
  - mean age 58 yrs, female 62%, mean Karnofsky 60
- **Role adoption**: At T2 and T3 better in intervention group than control group ($p<.01$)
- **Social supports**: Higher in intervention group at T2. No difference at T3.
- **QOL**:
  - Overall, no differences across 2 groups at T2 or T3,
  - But sub-domain analysis showed differences:
  - Higher scores in Intervention group for carer's own state (T2 and T3), caregiver perspective (T2), relationships (T2 and T3)

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Key Discussion Points

- Caregivers who received the PalliActive Training (relatively short)-along with its resources (materials, app) showed:
  - Superior role adoption (greater knowledge of the tasks, caring and specific to disease)
  - Improved organization (e.g. identifying and accessing supports)
  - Better response to the role (less negative impact of caregiving.
- Social support increased 2-weeks post education but not sustained
- Some aspects of QoL increased

Strengths

- Intervention is well described

Limitations

- Author reported: High attrition rate, at T1 and for some T2 assessments pts still in hospital, some limitations with intervention (e.g. ACP)
- Data collection occurred after intervention, not after discharge (time of caregiving exposure at home therefore varied)
- Irritants with reporting of results (text and tables misaligned); paragraph repeated

Impact on Practice

- **Highlights the importance of training and supporting caregivers for the role.**
- Further work needed on what to teach and how to teach and support.

Discussion

Honourable Mentions

Honourable Mentions

- Quarshie ND, Wells M, Dixon G, et al. **Interventions to address supportive care needs of people with pulmonary fibrosis and/or their caregivers: A scoping review**. Palliat Med.2025;39(5):604-621. doi:10.1177/02692163251326164

- Van Veelen A, Wijsenbeek MS, Koudstaal T. **Cough and dyspnea management in pulmonary fibrosis.** Current Opinion in Supportive & Palliative Care. 2025;19(2):103-110.doi:10.1097/SPC.0000000000000753

- Holland AE, Lewis A. **Evidence-based management of symptoms in serious respiratory illness: what is in our toolbox?** Eur Respir Rev. 2024;33(174):240205.doi:10.1183/16000617.0205-2024

- Pihlaja H, Rantala H, Leivo-Korpela S, Lehtimäki L, Lehto JT, Piili RP. **Specialist Palliative Care Consultation for Patients with Non-malignant Pulmonary Diseases: A Retrospective Study**. Palliative Medicine Reports. 2023;4(1):108-115. doi:10.1089/pmr.2022.0068

Wrap-up

- Please fill out our feedback survey a link has been shared in the chat!
- A recording of this webinar and a copy of the slides will be e-mailed to registrants within the next week.
- To listen to this session and previous sessions, check out the Palliative Care Journal Watch podcast.

Listen on Apple Podcasts

Listen on Google Podcasts

Listen on Spotify

NOTE: recordings, slides and links to articles from all our sessions are available at www.echopalliative.com/palliative-care-journal-watch/.

Thank You to our Journal Watch Contributors!

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Thank you | Merci

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