UNIT 4 PALLIATIVE CARE

Structure

4.0 OBJECTIVES

After reading this topic you will be able to:

- define palliative care;
- describe common clinical conditions with particular reference to malignancies where palliative care is more useful;
- enumerate the role of a doctor, nurses, social worker and caregiver in delivering the palliative care; and
- describe various medical and social problems which will be faced.

4.1 INTRODUCTION

In the previous units of this block, you have learnt about various types of malignancies and pattern of presentation of malignancies in elderly. Many a time you may come across the problem of managing an elderly cancer patient, in advanced stage of disease with multiple metastasis. It may manifest as disease of multiple systems with pain and anorexia in addition. The treating doctor can offer these patients only symptomatic relief rather than surgery or irradiation or any other active/anti-cancer treatment. Also elderly patient may have other associated problems like diabetes, hypertension and coronary artery disease. Patients with advanced stage of heart failure and respiratory disease and neurological disease will come to a terminal stage where symptomatic management is the goal of treatment so as to help them to meet their end of life in peace. As the number of old people are increasing, the number of patients with malignancy and terminal illness who need palliative care is also going to increase. The burden on geriatricians and primary care providers in this particular aspect is going to increase, so the knowledge about palliative care becomes vital.

4.2 WHAT IS PALLIATIVE CARE?

The aim of Palliative care is to provide supportive therapy and relief from distressing symptoms of terminal illness. Physical, psychological and spiritual support becomes essential to maintain quality of life till the end. This needs a team of physicians, nursing personnel, physiotherapist, social worker and primary caregiver, working in unison to provide maximum comfort to the patient.

4.2.1 Definition

Palliative care is defined as the active total care of patients whose disease is not responsive to curative treatment. Control of pain and of other symptoms and comprehensive management of psychological, social and spiritual problems is paramount.

4.2.2 Goals

The following are the goals of palliative care:

1) Patient should be free of distressing symptom like pain, dyspnoea, vomiting and constipation and live as actively as possible.

2) To provide adequate nutrition.

3) To provide psychosomatic and spiritual care for the patient.

4) To provide emotional support and relief to the family and caregivers, during the illness and during bereavement.

5) The palliative care should neither hasten nor postpone death.

4.2.3 Components

Basically one should provide psychological and social support in addition to providing relief from pain and other distressing symptoms. Wherever curative treatment is not possible for the underlying disease, palliative care is provided by the multi-disciplinary team with inpatient services, day care centres, home visiting teams and training services for the caregivers. Ideally the palliative care service includes a team of geriatrician, physiotherapist, oncologist, nursing personnel and caregivers.

4.2.4 Clinical Conditions Requiring Palliative Care

(1) Elderly patients with incurable and metastatic cancer are the major groups of patient where one has to provide palliative therapy. (2) Degenerative neurological disease like Alzheimer's disease, severe Parkinsonism, multi-system atrophy also require palliative care. (3) Physical disability leading to bed-ridden state, and contracture secondary to fracture or degenerative joint disease often need supportive care.

4.3 TERMINAL MALIGNANCY

Terminal malignancies form the leading cause of mortality and morbidity in the elderly as you have learnt in the earlier chapters. Symptoms of malignancy are often not clearly understood and elderly patients tend to underreport. Often, you have to encounter elderly patients with metastatic malignancy and concomitant disorders like cardio-respiratory problems which may limit active curative management of the malignancy. In these situations, you may have to target at symptoms relief and provide basic life support. We will now learn common symptoms in various malignancies and their management.

4.3.1 Symptoms in Advanced Cancer

Symptoms of malignancy depend on the site of malignancy and stage of disease. Pain is the commonest symptom that underlies any type of advanced stage malignancy. Cachexia and anorexia are the common distressing symptoms in any terminal malignancy. Dyspnoea is one

of the difficult symptoms you may have to manage in pulmonary malignancy as well as in any other malignancy with systemic spread. Malignancy often produces gastrointestinal obstruction, vomiting, constipation, distension and nutritional deficiency. Anorexia, nausea and vomiting are common symptoms both in gastrointestinal and systemic malignancy.

4.3.2 Pain—Types and Management

Pain is the principal symptom of any terminal malignancy. Incidence of pain is seen in 40% (e.g., GI malignancy) to 85% (bone metastasis) of patients with advanced stage of cancer. Before going into the mechanism by which the cancer causes pain, we should be aware that a cancer patient can have three types of pain.

a) *Baseline pain*—which is present always and is continuous in nature.

b) *Incident pain* is predictable pain associated with movement of particular area of the body or with any particular disease-related condition (organ obstruction or metastatic bone fracture).

c) *Breakthrough pain*, which is a very severe type of pain and comes without warning. It is usually due to irregular administration of the analgesic drug.

Mechanism of pain causation can be explained by three different pathophysiologic processes:

1) By malignant tissue infiltration of organ which is called as visceral pain,

2) Compression of nerve root/spinal cord known as neuritic (neuropathic) pain, and poorly localised dull aching (somatic) pain caused by bony metastasis or chachexia.

Usually an elderly cancer patient can have more than one type of pain with functional component also caused by of emotional upset or anguish. Pain can also be caused by anticancer treatment (chemotherapy or radiotherapy) or any condition (e.g., arthritis) or elderly age.

Before treating these patients an assessment should be made to know the type of pain because, the treatment differs for different types of pain e.g., neuritic pain can easily be controlled by drugs (e.g. carbamazepine) acting on various neural receptor levels. After initial assessment, the detailed examination and relevant baseline investigations should be done.

Management consists of three methods:

- Non-pharmacological method
- Surgery and/or radiotherapy
- Pharmacological method

Often combination of these methods may be needed for the desired results.

Non-pharmacological methods include acupuncture (counter-stimulation analgesia), transcutaneous electric nerve stimulation (TENS), ice massage, hypnosis, and distraction techniques to reduce the intensity of pain. Physical therapy in the form of heat is also useful. Surgery can be helpful in certain condition (feeding jejunostomy in oesophageal obstruction), so also radiotherapy is effective in bone pain due to metastasis.

Most of cancer pain can be controlled by pharmacologic methods and World Health Organization (WHO) has adapted a 3-step Ladder for cancer pain relief. Pharmacological relief of pain is brought about by 3 classes of drugs:

- Non-narcotic analgesics
- Narcotic analgesics
- Adjuvant drugs

Non-narcotic analgesics include paracetamol and other non-steroidal anti inflammatory drugs (NSAID). These constitute the first step in the management and can be used in combination with other analgesics. In the second step, paracetamol in combination with weak 6 opioid like

codeine or dextroprepoxyphene act synergistically in relieving pain. While prescribing NSAID, potential side effects like fluid retention, peptic ulceration and bleeding, nephrotoxicity etc. should be kept in mind.

Narcotic analgesics (strong opioids) as third step are extremely useful in elderly cancer patient with moderate to severe pain. Morphine is the strongest and most effective. Other opioids in the use are tramadol or oxycodone. Fentanyl is available as transdermal patches also. Morphine and oxycodeine are available for transrectal use. The severity of pain, rather than the person's age, should decide upon the usage of morphine.

Adjuvant drugs can be used along with the analgesics. They belong to different groups like steroids (for head ache, neuritic pain) anti-depressant (fluoxetine), anticonvulsants (e.g., Carbamazepine), anti-emetics, laxatives etc.

Anti-depressant and anti-convulsant are particularly useful for neuropathic pain, since they have long duration of action and can be taken conveniently at bed time. The following diagram (based upon WHO-3-step ladder) gives schematic idea about pain management (Fig. 4.1).

Type of Pain	Nature of pain	WHO Ladder	Choice of Drug	Other therapy
Somatic	Mild	Step 1	Paracetamol ± NSAIDs	Adjuvant drugs (See text)
Visceral				+
Neuropathic	Moderate	Step 2	Codeine ± Paracetamol, NSAIDs	Palliative Radiotheraphy (e.g., for bone metastasis) +
Mixed	Severe	Step 3	Strong opioid (oral) Strong opioid (Injection) Transdermal	± Palliative surgery (e.g., Nerve ablation)

Fig. 4.1: Type, Nature and Management of pain

* Let us take the example of a clinical case. 65-year old lady with a diagnosis of left sided breast has developed metastases to lumbar spine, liver and brain. For her pain management, you can initially start with 1. Paracetamol (500 mg 6 hrly), 2. Ibuprofen (400 mg 8 hrly), 3. Prednisolone (20 mg 12 hrly-for liver and brain), 4. Ranitidine (150 mg 12 hrly or an antacid). Addedly she should be given palliative radiotherapy to lumbar vertabrae and brain. With these measures, if she still has persisting pain, then she should be presecribed codeine (30 mg 4 hrly) or morphine (10 mg 4 hrly) orally. Along with codeine/morphine, she will need the adjuvant drugs — perinorm (1 tab 8 hrly) and dulcolax (2 tabs at bed time). More than 80% chance would be that she would be responsive and comfortable with the above medications.

Some common drugs and their dosages are as below:

Drug	Route	Dosage
Dexamethasone	Oral/IV/IM	12-16 mg/24 hrs.
Amitryptyline	Oral	10-150 mg/24 hrs
Carbamazepine	Oral	200-600 mg/24 hrs
Morphine	oral/IM/subcutaneous	5-30 mg/4 hrly

Check Your Progress 1

1) List the clinical conditions requiring palliation.

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2) What are the objectives of palliative care?

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3) Mention different types of pain.

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4) What is adjuvant pain therapy?

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4.4 GASTROINTESTINAL SYMPTOMS IN MALIGNANCY

We have often seen GI symptoms in any type of malignancy with systemic spread. Anorexia, nausea, vomiting, intestinal obstruction and constipation are the common symptoms we have to manage. More than 40% of patients with advanced malignancy suffer from nausea and vomiting. These symptoms are often due to malignancy itself, or due to chemotherapy and radiotherapy and sometimes other conditions like metabolic changes, raised intra-cranial pressure, GI obstruction and hepatic insufficiency. Vomiting often leads to secondary complications like dehydration and electrolyte imbalance. Vomiting secondary to chemotherapy usually respond to prochlorperazine, haloperidol or ondanestron.

Metaclopramide, domperidone, and ranitidine are useful in vomiting due to gastroparesis. Except in intestinal obstruction, regular use of laxatives will relieve constipation.

4.4.1 Anorexia, Nausea and Vomiting

Next to pain, these are the common symptoms. These in turn cause inability to eat and will lead to further malnutrition. The reason for these symptoms are multiple like iatrogenic (drug induced), radiotherapy, chemotherapy, metabolic distrubances, raised intracranial tension, direct invasion of GI system etc. Haloperidol 1.5-3 mg will be very useful in controlling drug induced/radiotherapy induced vomiting. 5-HT3 receptor antagonist (Ondansetron), metadopramide and octreotide will help in controlling chemotherapy induced vomiting whreas cisapride and domperidone will control vomiting caused by gastric irritation. Sometimes emotional upset and anxiety can also cause vomiting and should be thought of as cuases in controlled vomiting. In the presence of anxiety, diazepam (5mg 12 hourly) or lorazepam (1-2 mg 12 hourly) along with domperidone or metaclopramide are very useful.

4.4.2 Constipation

Like other symptoms, causes of constipation are various including immobility, lack of fiber in diet, drugs, hypercalemia and direct effect of tumour. All patients should have rectal examination done and faecal impaction if any should be relieved. Other precipitating factors should be treated appropriately. Appropriate use of stimulants, stool softeners, and enema either alone or in combination will relieve the symptoms of most patients. Ideally cremaffin (4 tsf at night) or Dulcolax (2 tabs at night) is prescribed. If needed, glycerol enema can be given.

4.4.3 Parenteral Nutrition

Most terminally ill patients, particularly those who are demented, suffering from malignancy of upper GIT, or neuromuscular disorder might need nutritional support in one or other form. The nutritional support could be in the form of intravenous fluids or tube feeding. Each has its own merits and demerits. In the terminally ill cancer patients intraverous fluid is not an ideal management to maintain the patient for a prolonged period.

Tube feeding can be given either via nasogastric tube or by percutaneous gastrostomy. Aspiration, tube blockage, infection, dislodgement and diarrhoea are some of the complications of long term tube feeding.

4.5 DYSPNOEA AND TERMINAL RESTLESSNESS

Dyspnoea is also another subjective feeling like pain where the patient has difficulty in breathing and air hunger. Its causes are multifactoral and patients emotion also will play a part. Dyspnoea occurs in patients with malignancies usually from lung colorectal, breast and prostate cancers. It could also be due to infection, metabolic problems and cardiac disease. Patients with neurodegenerative disorders usually die of respiratory failure and dyspnoea may be the prominent terminal symptom.

Management of Dyspnoea

1) ***Non Pharmacological Methods***

As we know emotion, anxiety and fear *per se* can cause dyspnoea. This can be tackled by following means. Explanation and reassurance to the patient is important. Physicians and nurses should spend some time daily by the bed side of the patient and listen to their feelings to alleviate unwanted fears.

The patient should be placed in a comfortable airy room and proper position in the bed is to be maintained.

Relaxation exercises and breathing exercise can also help them.

2) ***Pharmacological Methods***

As for pain, opioids are useful in dyspnoea. Morphine in particular, through its action on cerebral cortex, respiratory centre and on pulmonary receptor can control dyspnoea to a great extent. Anxiolytics like diazepam will help in a anxious patient. Nebulized salbultamol is particularly useful in patients with dyspnoea due to malignancy.

In addition to above measures nasal oxygen will be of help in correcting hypoxia.

Terminal Restlessness

This is a distressing symptom for patient as well as the caregivers. Various causes like unrelieved pain, anxiety, fear, bladder fullness, dyspnoea, cough, drugs, infections, metabolic disturbances and dehydration can result in restlessness.

In addition to analgesics and sedatives, the management primarily depends on identifying the cause and correcting it.

Check Your Progress 2

1) Mention GI symptoms in malignancy.

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2) What are the methods of managing dyspnoea?

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4.6 NURSING CARE IN TERMINALLY ILL PATIENTS

Nursing care is as important as doctor's care, as the nurses are the ones who spend more time than a doctor, in care of terminally ill patient. The nurse should have good training in caring for these people, should be knowledgeable about symptom-related verbal communications and physical findings in elderly patients with advanced cancer or terminal illness. She should also be able to counsel the patient while doing general nursing. As far as the care of terminally ill, their role is very important in preventing bed sores, aspiration, and infection and in providing fluid and nutritional balance.

Prevention of Bedsore

As bedsores are difficult to be treated, it is important that it should be prevented. A nurse's role is to inspect the skin daily to look for any inblanchable erythema, an early sign of bed sore. If so, pressure should be avoided over the bony prominence and patient's bed should be changed to alpha-bed. In addition, a nurse should be attentive to prevent contamination of skin by urine/faeces and to avoid constipation and subsequent diarrhoea. She can train the family members to help her. The nursing personnel will be in a better position to supervise the diet of the patient to maintain adequate nutritional requirement.

Prevention of Aspiration

Maintenance of proper position of the patient will help in many ways. It can ease dyspnoea, prevent aspiration and ward off infections of chest, kidney, bladder etc. This will motivate the patient to view his surroundings, and interact with each other. A good nurse can assess the patient's capacity to ambulate and guide them accordingly. Properly maintained and graded physical therapy is helpful in preventing wasting, contracture and pressure sores

4.7 PSYCHOLOGICAL SUPPORT IN TERMINAL ILLNESS

As expected in any terminally ill patient, elderly patients also express denial, guilt, anger and other unfulfilled wishes.

The caregiver often suffers from depression and other components of bereavement. As an experienced person, a doctor or a nurse can tackle these things better than others. The medical team can identify warning signs of depression so that useful intervention can be made and counsel the patient and the relatives.

Some patients express their wish to die in their house. Nurses role become vital in taking care of those patients and help them to die peacefully.

A financial problem in old age affects the management of malignancy and terminal illness. Medical facility, compliance and follow-up becomes difficult due to financial constraints. Caregivers get less support from others in management of elderly with cancer. They tend to develop depression and other psychological problems. The social support from friends and

other family members progressively declines at the late phase of illness and caregivers become isolated with the patient.

Anticipating and identifying these problems in the caregivers and providing necessary psychological and social support is an essential part of palliative care.

Check Your Progress 3

1) Mention the role of nursing in palliative care.

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2) Explain the need of psychological support in terminally ill.

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4.8 LET US SUM UP

In this unit we have learnt that palliative care is essential in alleviating the symptoms and maintaining quality of life in terminally ill elderly patients. Pain forms the common distressing symptom requiring multi-model approach to provide adequate relief. GI symptoms like nausea, vomiting, constipation, obstruction need attention to provide symptom relief and to improve nutrition. Dyspnoea and terminal restlessness are often difficult to manage. Palliative care needs a team approach and therapy should be individualized. Comprehensive management of physical, psychological and social problems will improve the quality of life in terminally ill elderly.

4.9 KEY WORDS

Adjuvant therapy : methods of improving primary therapy.

Cachexia : gross wasting, nutritional deficiency

Palliation : symptomatic and supportive therapy (non-curative)

4.10 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress

1) Clinical conditions requiring palliation are:

   — Terminal Malignancy

   — Degenerative Neurological disorders like Dementia

   — Physical disabilities leading to contracture and bed ridden state

2) Objectives of palliative care are:

   — Control of pain, dyspnoea and GI symptom

   — To provide nutritional support

   — Psychological and social support to maintain quality of life

3) Pain can be classified according to:

   — pain mechanism — somatic pain, visceral pain and neuritic pain

   — pain severity — baseline pain, incidental pain and breakthrough pain

4) — Anti convulsants, anti depressants and steroids are useful in neuritic pain and enhance other analgesics effects. These are called adjuvant drugs.

Check Your Progress 2

1) The gastrointestinal symptoms in malignancy are:

   — Anorexia, nausea and vomiting

   — Constipation

   — GI obstruction

2) There are both non pharmacological and pharmacological methods of managing dyspnoea:
   — Non pharmacological methods: reassurance, relaxation and breathing exercises proper positioning in well ventilated room

   — Pharmacological methods: Anxiolytics, morphine and bronchodilators like Nebulised salbutamol

Check Your Progress 3

1) The role of nursing in palliative care are:

   — To maintain fluid and nutritional balance

   — Prevention of bedsore, aspiration, contracture and infection

   — Identifying medical emergencies

   — Providing psychological support to patient and his family

2) — Depression is common in patient and caregivers

   — Financial problem and compliance of therapy

   — Lack of social support