You can control symptoms

Modules 11 and 14

Principles of symptom control

- **Assess** the symptom thoroughly
- **Treat** the treatable
- **Care** for the patient
- **Prescribe** medication as needed

Common symptoms

- pain
- nausea and vomiting
- constipation
- bowel obstruction
- breathlessness
- confusion / delerium
- lymphoedema
- fungating tumours
- bleeding
- weakness and anorexia
  - etc………..

Symptom control

- recognition most important
  - needs assessment
  - pain as 5th vital sign
  - inclusion in CME and training
- reference and guidelines
  - 11 guidelines shared plus essential medicines list
- ensure referral support to specialist services

PALLIATIVE CARE GUIDELINES: BREATHLESSNESS MANAGEMENT

Principles:

- Breathlessness (dyspnoea) is a distressing symptom experienced by many patients with advanced disease.
- It is a subjective experience and should not be confused with tachypnoea that is an objective clinical sign.

Assessment:

- Take a full, holistic history from the patient and complete a clinical examination.
- Order any appropriate investigations e.g. CXR, CBC.

Management:

- Good holistic care requires a combination of general non-clinical measures and advice, investigation and treatment of any underlying cause(s) and appropriate symptomatic treatment(s). All three aspects of care are important and ideally should occur concurrently, however for certain patients the underlying cause of the breathlessness may be unclear. Management for these patients should focus on improving symptoms and quality of life whilst regularly reassessing.

General measures	• Reassure the patient – breathlessness can be extremely frightening, and is exacerbated by anxiety. Explore the patient's fears and concerns. • Breathing exercises and relaxation techniques are often beneficial and should be taught to the patient: o Explain that their breathing will improve if they slow it down. Show them how to slow their breathing by pursing their lips as if they were going to whistle when they breathe out. o Teach the patient to breathe with their diaphragm rather than the top of the chest by putting one hand on their chest and one on the top of their abdomen so they can feel where they are breathing from. The hand on the abdomen should move more if they are breathing with their diaphragm. • Find the most comfortable position for the patient (usually sitting up). • Ensure good ventilation – open windows and/ or use a fan. Loosen any tight clothing. • Conserve energy by limiting or reducing activities.
Treat underlying cause(s)	• History, examination and investigations should focus on finding or excluding underlying causes for breathlessness. • Reverse/ treat any underlying cause(s) identified appropriately.
Symptomatic treatment	• Low dose morphine e.g. 2.5-5mg po 4 hourly can improve symptoms of breathlessness (if already on morphine for pain control, increase the dose by 30% and advise on taking breakthrough doses as required). • Diazepam 2.5-5mg po up to tds. This can be very helpful when the breathlessness is associated with significant anxiety or panic attacks. • Consider oxygen if hypoxic (however there is no evidence to support the use of palliative oxygen in patients with normal oxygen saturations). • Regular nebulised saline 0.9% may be helpful for patients with sticky bronchial secretions.

These guidelines are applicable to patients with chronic life limiting illnesses. Patients whose symptoms fail to respond to initial measures should be referred to the MPCU (Mulago Palliative Care Unit). Referrals can be made via consultation request form HF204 delivered to the palliative care ward office on ward 4A or via phone (MPCU Mobile: 0779490784). These guidelines are based upon and designed to be used alongside other resources such as the Palliative Care Toolkit, APCA pocket book and HAU blue book (available via MPCU)

6th January 2012.

Scenarios and role play

- *Use the scenarios from Resource 8 and 12 TTM, from a clinical bedside session or from local experience to discuss the management of common symptoms in children and adults*
- *Role play can be a useful tool*
- *Refer to MPCU guidelines, Toolkit, APCA pocket books or other resources as you work through the scenarios*
- *The following cases are examples of how to do this and can be adapted to the specific setting*

Role play

- You are reviewing a young 12 year old child who has metastatic osteosarcoma to his lungs. He is now very unwell and you know he will not live for many more weeks. He is very breathless and frightened. He keeps pulling off his oxygen mask.
  - What can you do for this child?
  - What will you say to his father who asks you why you are not making his son better

Case study

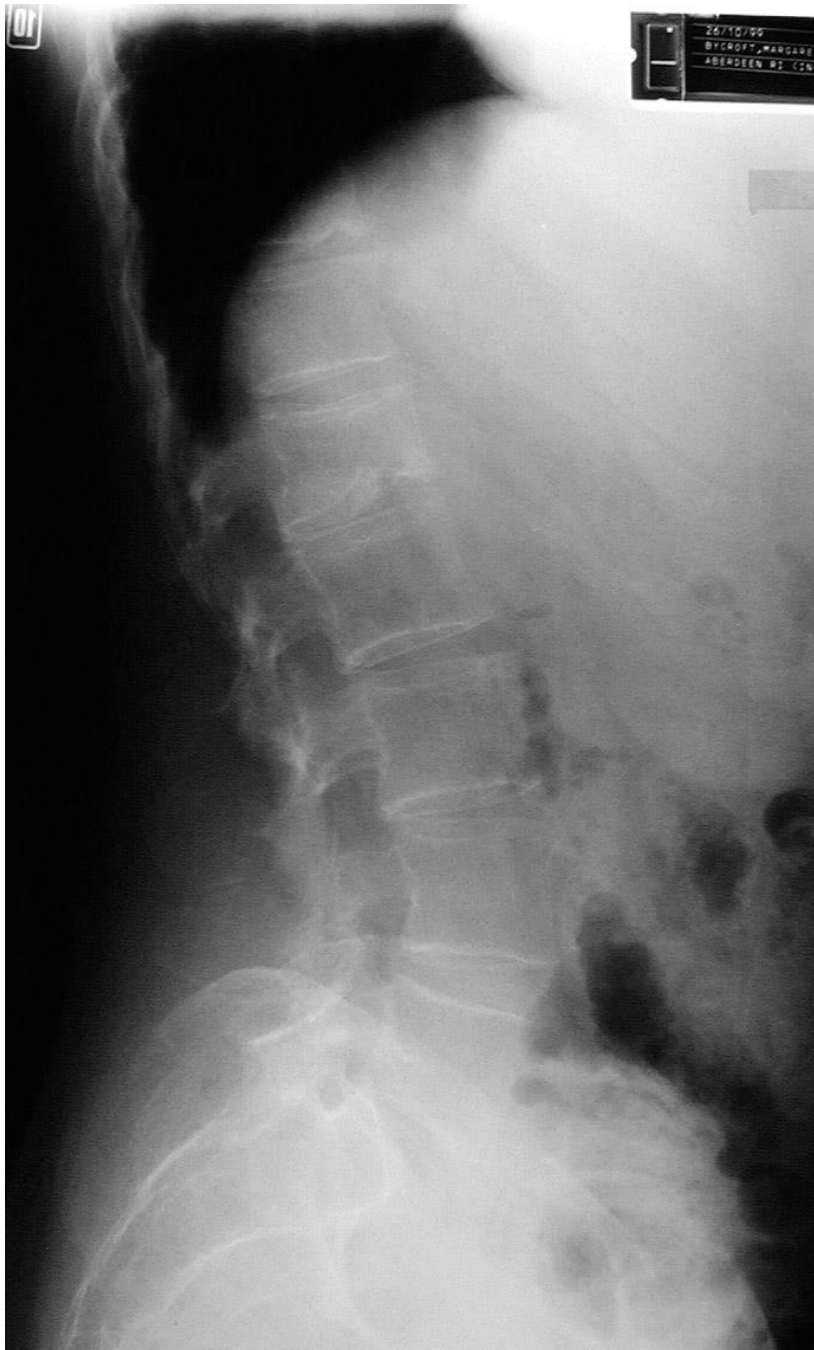
- Martha is a 38 year old woman who has cancer of the breast treated with surgery, RT and chemo 2 years ago
- her disease had been under control but now she has developed bone secondaries
- she is the mother of two children; Blessing (10years) and Grace (13 years)

Case study

- Martha is from Mbale but married and moved to Kisoro. Her family are all still in Mbale but her frail mother-in-law lives with them.
- Her husband is unemployed and spends much of the day drinking. He seldom speaks to Martha about her illness or her worries but her sister-in-law is a good support.

Case study

- She has excruciating pain in the chest, and over her lower back and is unable to sleep. She feels like there is a burning band round her chest.
- Questions
  - What are the likely causes of her pains?
  - What are the options for management?
  - Why is she not sleeping?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Case study

Task

- Write a prescription for Martha’s pain problems

Case study

- Martha's current prescription is;
  - oral morphine immediate release 10mg 4 hourly and as required
  - paracetamol 1g 4x
  - amitriptylline 25mg at night
  - bisacodyl 10mg daily
- She is worried she might become addicted to morphine .
  - How will you respond to this question?

Case study

- On her next visit, when you ask her about how she feels, she looks nervous.
- She asks ‘What is going to happen to me’
- Questions
  - How do you respond to this question?
  - Think of exact words or response?
  - What should you avoid?

Case study

- She complains of constipation
- Questions
  - Why is she constipated?
  - How will you manage her constipation?

Constipation

- anticipate
- dietary advice
- encourage fluid intake
- use softener / stimulant laxative combination
  - *liquid paraffin 10-15mls od bisacodyl 10mg od - tds*
  - consider rectal management

Case study

- She has poor appetite and bloated. She vomits after meals
- Questions
  - What further questions do you want to ask?
  - What are the likely causes of her symptoms?
  - How will you help her symptoms?

Nausea and Vomiting

- common symptoms
- 40-70% patients with advanced cancer
- unrelenting nausea ? worse than pain

Nausea and Vomiting

Causes

- gastric stasis and outflow obstruction
- chemically induced
- visceral stretch / irritation
- raised intracranial pressure and meningism
- other

Nausea and Vomiting

Gastric stasis and outflow obstruction

- drugs
  - anticholinergics
- autonomic failure
  - nerve infiltration / paraneoplastic / diabetes
- ascites
- hepatomegaly
- tumour infiltration
- peptic ulcer / gastritis

Nausea and Vomiting

Gastric stasis and outflow obstruction

- features
  - epigastric discomfort
  - worse with eating
  - relieved by vomiting
  - early satiety
  - provoked by moving torso
  - assoc. reflux / hiccup

Nausea and Vomiting

Chemical induced

- drugs
  - antibiotics / opioids / digoxin
  - anti-inflammatories / anticonvulsants
- metabolic
  - renal failure / hepatic failure / ketoacidosis
  - hypercalcaemia / hyponatraemia
- toxins

Nausea and Vomiting

Chemical induced

- features
  - constant nausea
  - intractable
  - vomiting variable
  - ?signs of drug toxicity

Nausea and Vomiting

Visceral stretch / irritation

- hepatic metastases
- ureteric obstruction
- retroperitoneal nodes / tumour
- constipation
- bowel obstruction

Nausea and Vomiting

Visceral stretch / irritation

- features
  - constant nausea
  - vomiting less common
  - pain often associated
  - other features relating to cause

Nausea and Vomiting

Raised intracranial pressure / meningism

- intracranial tumour
- cerebral oedema
- intracranial bleeding
- meningeal infiltration by tumour
- skull metastases
- cerebral infection

Nausea and vomiting

Pattern	Causes	Suggested medication
Gastric stasis or delayed bowel transit time • Early satiety	• Medications, e.g. morphine • Constipation • Gastric outflow obstruction "squashed stomach syndrome"	• Metoclopramide 10-20mg 8 hourly 30 mins before meals (same dose sc or iv)
Metabolic disturbance or toxins • Intractable nausea that is typically not relieved by vomiting	Metabolic: • Renal failure, liver failure, hypercalcaemia Toxic: • Medications e.g. morphine • Chemotherapy +/- Radiotherapy	• Haloperidol 2.5mg nocte (po or sc)
Raised intracranial pressure • Typically worse in the mornings and often associated headaches • Nausea typically not relieved by vomiting	• Intracranial tumours • Infections e.g. toxoplasmosis • Meningitis (TB, cryptococcal) • Malaria	• Dexamethasone 8-16mg od po or iv (caution in patients with untreated infections which should always be treated first)
Bowel obstruction	• If surgery ineffective, conservative management of malignant bowel obstruction can improve symptom burden – refer patient for specialist support	

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ABERDEEN ROYAL
INFIRMARY (IN-PATIENTS)

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ABERDEEN ROYAL HOSPITALS

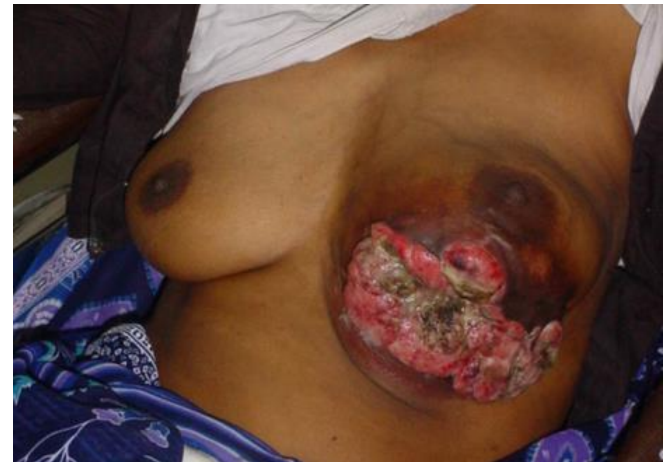
Bowel Obstruction

Symptoms

- pain
  - background / colicky
  - morphine / buscopan
- nausea
  - continuous / intermittent
  - metoclopromide / haloperidol
- raised intra-abdominal pressure
  - bloating / reflux / constipation / SOB
  - steroids / local measures

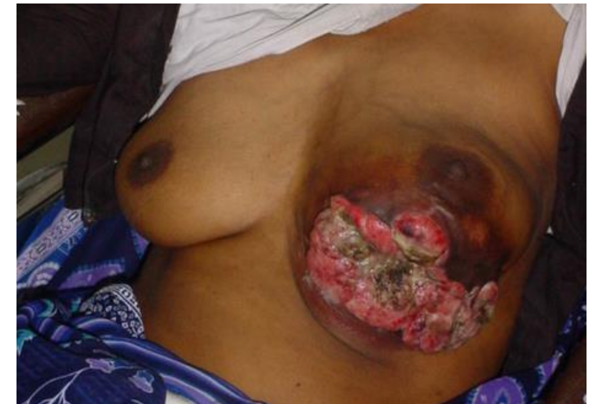
Case study

- Her local disease has now progressed and she has a foul smelling fungating mass
- Questions
  - How can we help this problem?
  - How might this problem affect her?



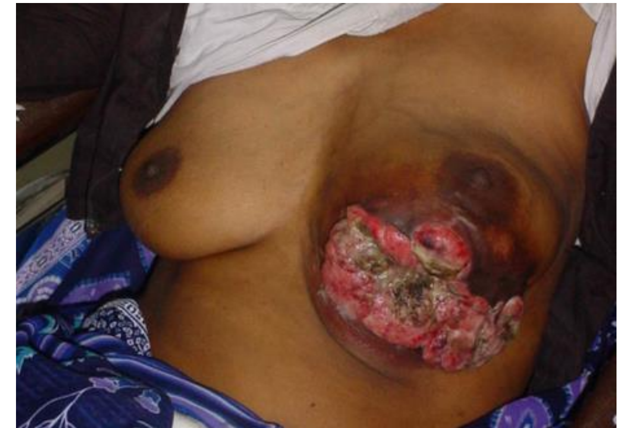
Fungating tumour

- Wound cleaning
  - use normal saline wash and soaks
  - avoid antiseptics or debriding agents
    - avoid hydrogen peroxide especially
  - simple measures at home
    - pinch salt in glass of boiled water (200mls)
  - regular wound dressing
  - regular showers
  - ensure dressing non-adherent



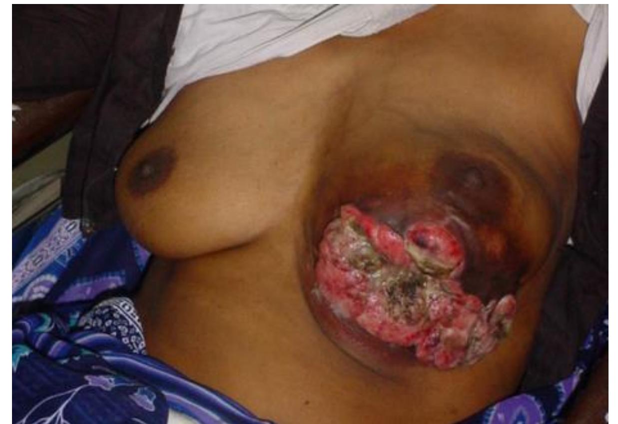
Fungating tumour

- Odour
  - metronidazole tabs crushed and powered then sprinkled onto clean wound
  - may have access to metronidazole gel
  - frequent dressing changes
  - clean wound
  - well ventilated room



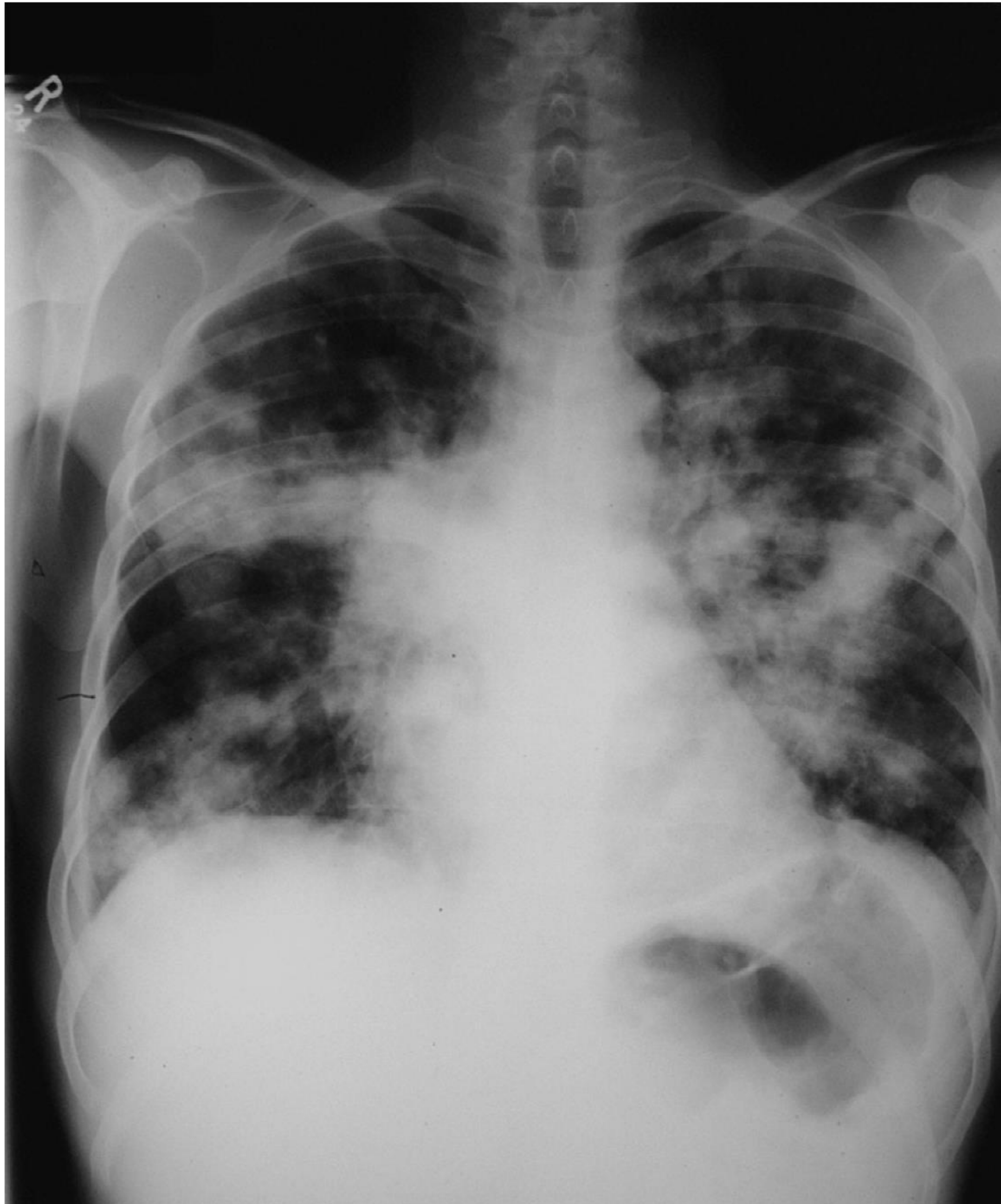
Fungating tumour

- Pain
  - review oral analgesia
  - consider topical agents
    - lignocaine gel
    - (bupivicaine soaks before dressing)



Case study

- Martha has been deteriorating steadily for the last three months, and has now has widespread pulmonary and liver secondaries. She is feeling breathless after even mild exertion and has a troublesome cough. She tells you she feels frightened.
- Question
  - How will you approach these problems?



Breathlessness

Pharmacological management

- opioids
  - **oral morphine**
- benzodiazepines
  - **lorazepam / midazolam / diazepam**
- steroids
- oxygen
- other
  - **phenothiazines**
  - **bronchodilators**

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Breathlessness

Non Pharmacological management

- find a comfortable position
- open windows and use a fan
- help to conserve energy
- talk and support anxieties
- help with breathing techniques

Breathlessness

Effects of opioids on resp. sensation

- analgesia
- cerebral sedation
- reduced anxiety
- improved cardiac function
- reduced sensitivity to hypercapnia
- local effect on airways opioid receptors

Case study

- Martha has became increasingly agitated and confused. She seems distressed and her family are finding this very difficult.

Question

- What might be the underlying causes:
- What will you d to investigate and manage?

Confusion

Confusion, delirium, dementia

- Causes
  - infections
    - HIV dementia
  - tumours
  - substance use
  - medications
  - metabolic disturbance

Confusion

- Management
  - treat or remove causes
  - emphasis non-drug measures
    - reorientation
    - reassurance
    - calm environment
    - carer support
  - *haloperidol 2-5mg po/sc*
  - *diazepam 2.5-5mg or lorazepam 0.5-2mg*

Case study

- Martha is now very close to the end of her life and wants to stay at home. Her breathing is sounding moist and there is a rattling sound. Her family calls their doctor asking for help and suggest bringing her to hospital for admission?
- Question
  - How will you respond to this cry for help?

End of life care

- Pharmacological
  - death rattle

    hyoscine butylbromide 20-40 mg qds
  - agitation

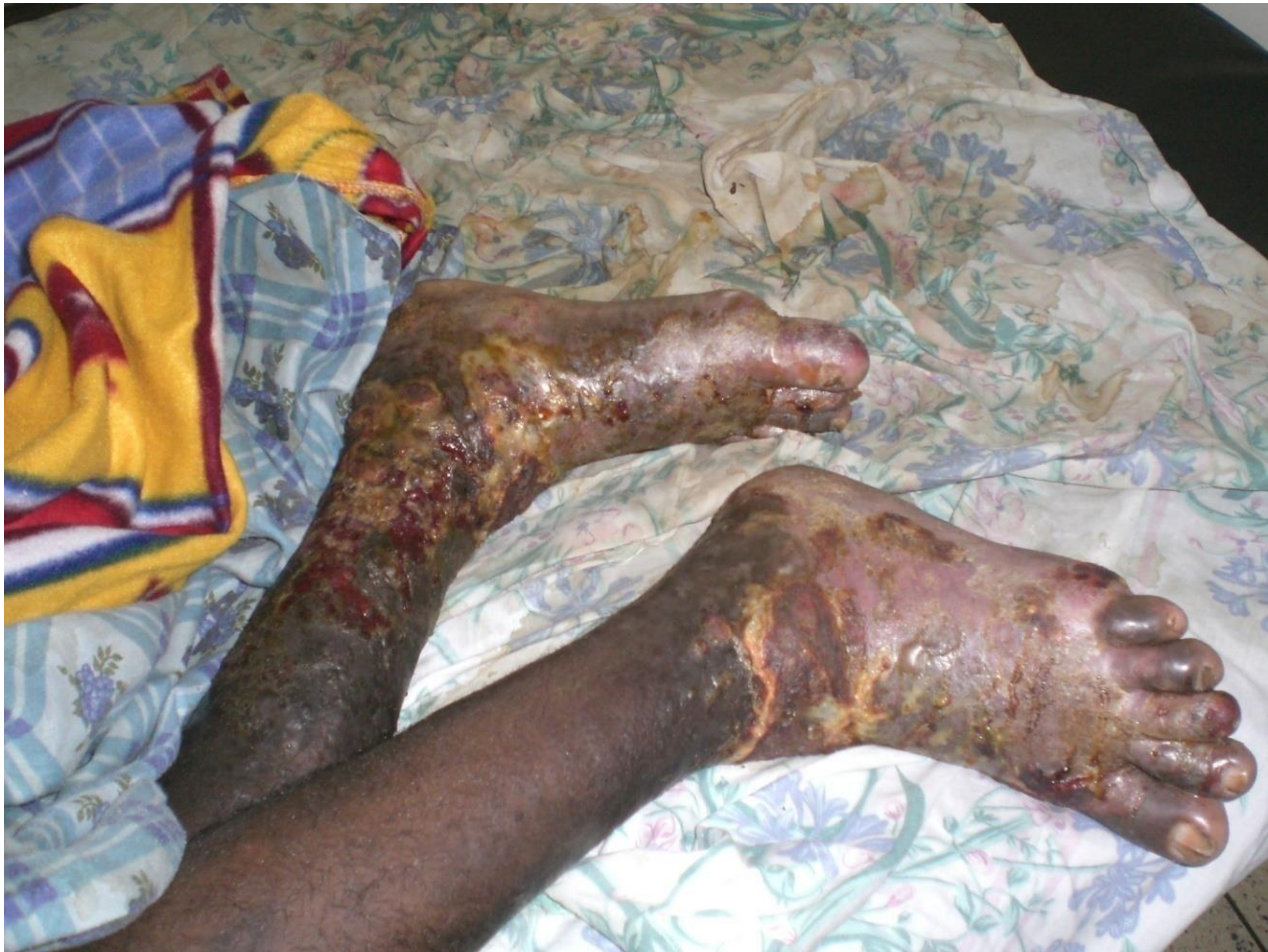
    haloperidol 1-5 -2.5 mg s/c 2-4 hrly

    midazolam 2.5-5 mg s/c 2-4 hrly
  - pain

    morphine 2.5 – 5 mg s/c 4 hrly

Case scenario

- Swaibu arrives at the casualty
- he has advanced KS and now has excruciating leg pain
- he has travelled some distance and has not been having any regular analgesia
- *Questions*
  - How will you assess Swaibu's pain?
  - What are your differential diagnoses?



Case scenario

- On your ward round you notice ben has a new sheet and some food as well as a bible
- You know he comes from a Muslim family
- How do you respond?

Case scenario

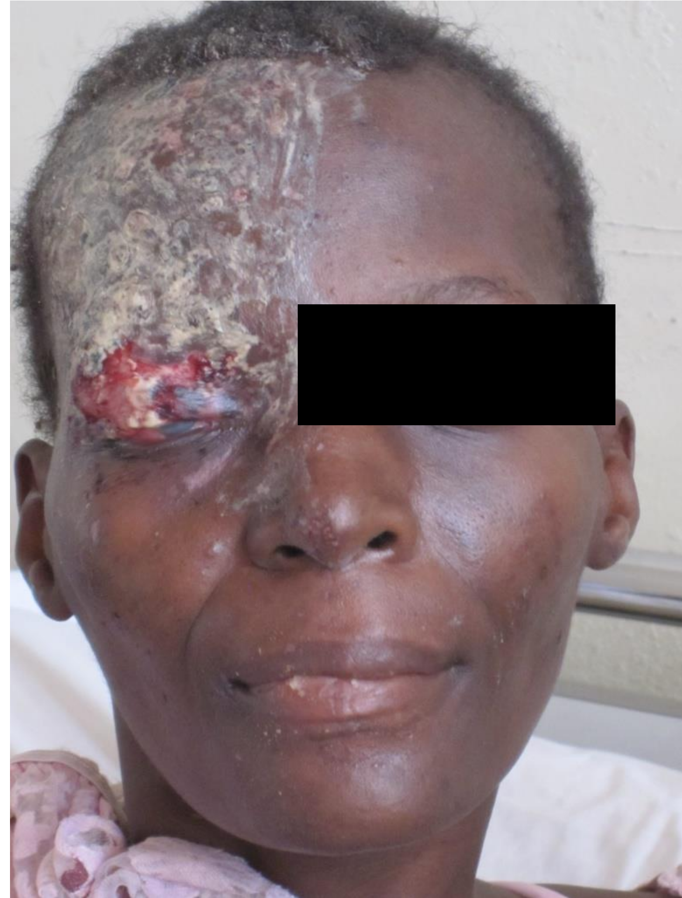
'when I see you coming with the team I feel so much better. God has answered my prayers and I know that he cares for me. I no longer feel angry and sad. I can sleep at night instead of crying. I now have hope. Thank you.'

Case scenario

- 30 year woman
  - HIV+ve
  - Septrin prophylaxis
  - CD4 150
  - has not disclosed diagnosis to spouse
  - *'He will leave me and take the children if I tell him'*
- Admitted with severe pain
  - rash orbital area
  - severe allodynia (tears are even painful)
  - started on carbamazepine 200mg

Case scenario

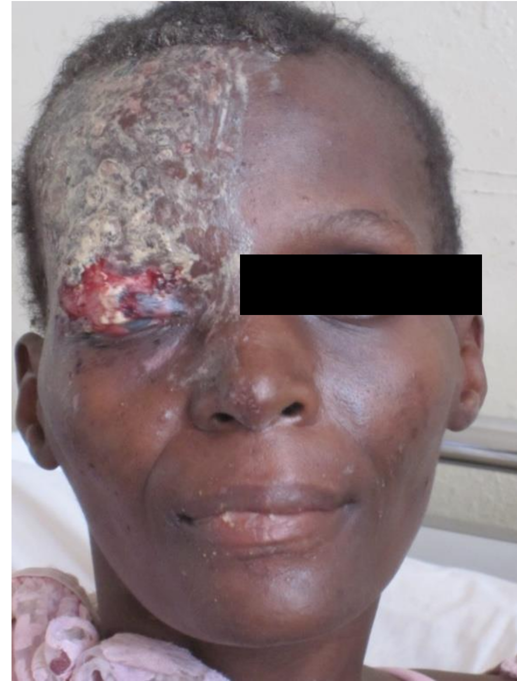
- *Question*
  - How will you help this woman?



Case scenario

Management; physical

- HZ
  - acyclovir
- analgesia
  - morphine 5 mg 4hourly
  - amitriptylline 25mg
  - bisacodyl 2 tabs



Case scenario

- 12 year girl
  - newly diagnosed hepatocellular carcinoma
  - severe right upper quadrant pain
  - only carer in hospital is sister who is not educated
  - both parents died when she was a baby from HIV/AIDS
  - grandmother in village near but cannot afford transport

Case scenario

- *Question*
  - How will you help this young girl and her family?
  - She asks you 'what is going to happen to me'
  - How will you respond?

Case scenario

- *Management; physical*
  - oral morphine 5mg 4 hourly
  - bisacodyl 2 tabs daily
  - dexamethasone 8mg 2 days and then reduce

- These resources are developed as part of the THET multi-country project whose goal is to strengthen and integrate palliative care into national health systems through a public health primary care approach
  - Acknowledgement given to Cairdeas International Palliative Care Trust and MPCU for their preparation and adaptation
  - part of the teaching materials for the Palliative Care Toolkit training with modules as per the Training Manual
  - can be used as basic PC presentations when facilitators are encouraged to adapt and make contextual

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