

Symptoms (other than Pain) Control in Palliative Care

Dr. Folaju O.Oyebola
Chief Consultant Anaesthetist / Palliative care Physician
Head, Pain & Palliative Medicine Department
Federal Medical Centre, Abeokuta, Nigeria.
fooyebola@yahoo.com

Learning Objectives

- To highlight the causes of symptoms in terminal cancer patients.
- To discuss the pharmacological and non-pharmacological approach to symptom control.
- To demonstrate symptom control as essential skill for all health care providers.

Definitions

Define “Palliative Care”

- Is an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness.
 - **through the prevention and relief of suffering by means of**
- early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

(WHO 2002)

Symptom Control

Patients with life threatening illness

- improves the quality of life
- **through the prevention and relief of suffering**
- early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial – **SYMPTOMS.**

(WHO 2002)

Presentations

- 40-70% of Terminally – ill (TI) patients or advanced Ca patients will present with one or 2 symptoms.
- May be related or unrelated directly or indirectly with the malignancy.
- Indirect – S/E of Chemo/Radiotherapy
- Physical or Psychosocial symptoms

Pattern of Symptoms Presentations/Prevalence

Pain	47%	Lack of energy	74%
Activity	99%	Worrying	70.9%
Nausea	20%	Feeling sad	66.1%
Depression	44%	Pain	62.7%
Anxiety	49%	Feeling Nervous	61.9%
Drowsiness	72%	Drowsiness	61.0%
Appetite	76%	Dry Mouth	56.5%
Well Being	80%	Sleep difficulty	53.7%
Shortness of Breath	50%		Portenoy et al 1994
Eduardo Bruera 2004			
Pain	80%	Pain	59%
Fatigue	90%	Delirium	56%
Weight Loss	80%	Fatigue	52%
Lack of Appetite	80%	Anorexia	40%
Nausea, Vomiting	90%	Dyspnoea	33%
Anxiety	25%	Drowsiness	33%
Shortness of Breath	50%	Edema/ascites	33%
Confusion-Agitation	80%		Marvin et al 2004
Eardie A Curry 2004			

Classifications

Physical or Psychosocial symptoms

- Physical – Anorexia, Cachexia, Fatigue
- Systemic
 - Respiratory- Dyspnea, Cough, Sputum
 - Gastrointestinal- Nausea/Vomiting, Constipation
 - Cardiac - Dyspnea
 - Uro-genital
 - Mental – Delirium
 - Metabolic –Hypercalcemia, Electrolyte imbalance

Psychosocial

- Anxiety - as a result of disease condition

- may indirectly cause breathlessness

Required explanation & reassurance. ? Cause.

Rx. of associated breathlessness - Mild sedation with Diazepam, Haloperidol.

- Relaxation / Re-breathing exercises

- Use of Benzodiazepines – may cause delirium

- Depression

Pancreas, Breast, Colon, Gynaecancers, Lymphoma, oro-pharynx, Gastric

- Diff. dx.-Uncontrolled pain, Delirium, Dementia, Grief, Electrolyte abnormalities

- Rx: Antidepressants

- Antipsychotics

- Anxiolytics

- Counseling

- **Psychotherapy**

Respiratory

<p><u>Acute Dyspnea</u> O2 Demand > Body ability to supply O2 Acute hypoxia – Agitated confusion Hypoxic & Non hypoxic dyspnea Increased FIO2 – intact lung 100% O2 4-5L Insufficient Lung – Pharmacological control Low dose Morphine – oral / sc</p>	<p><u>Non-pharmacological</u></p> <ul style="list-style-type: none"> •Communication- gentle & sure explanation •Massage, chest / re-breathing exercises •Distraction technique - music •Increase air movt. - fan, open windows •Comfortable position – sit upright
<p><u>1. Ventricular failure</u> -Frusemide 40mg + Vasodilators –ACE inhibitors <u>2. Pericardial effusion</u> - Hypertension, Dyspnea, Tachycardia Rx. Pericardial paracentesis under ECG 5. <u>Superior Vena cava Obstruction</u> – Frusemide, Radiotherapy for a radiosensitive tumour, ditto for chemo-sensitive ones</p>	<p><u>4. Tracheal obstruction</u> Dexamethasone 24mg i/v or P.O Oxygenation – O2 / Helium mixture 6. <u>Pulmonary Tumour</u> – Carcinomatosis L. Ca lung -High dose steroids 18-24mg Dexamethasone (peritumor oedema) -- Radio/Chemotherapy/Hormone Therapy --Chemotherapy – Small cell Ca --Hormone therapy – Breast Ca.</p>

Respiratory

<p>3. Pulmonary Embolism</p> <p>4. Pleura Air / Pneumothorax</p> <p>5. Pleura effusion</p> <p>6. Pleurisy</p> <p>7. Infection – sputum m/c/s</p> <p>8. Anaemia</p>	<p>O₂, Anticoagulants –heparin / warfarin</p> <p>-Intercostal drainage</p> <p>-Aspiration / drainage , Pleurodesis</p> <p>- Intercostal block +/- NSAIDS</p> <p>-Cloxacilin, Erythromycin</p> <p>-Transfused Hb < 9g/dl</p>
<ul style="list-style-type: none"> •Dyspnea •Cough - dry •Sputum 	<p><u>Rx.</u> Single spray</p> <p>2%lignocaine 1-2hrly, lozenges, menthol inhalation</p> <ul style="list-style-type: none"> •Increase room humidity •Moist sputum –Hyoscine Sc. •Tenacious sputum- Nebulised saline •Mucolytic agent

Anorexia & Weight loss

- Common presentation
- Rx.
 - Explanation to patient and family
 - Dietary advise
 - Steroids including megestrol acetate

Nausea & Vomiting

Sensors

- **Cerebral cortex** – hypersomnolence from visual, smell, taste & memories may be emetogenic.
- **CTZ** – inputs from drugs/toxins via dopaminergic pathway
- Rx – anti-dopaminergics – Metoclopramide, Haloperidol
- **Vomiting centre** - Histamine(H)₁, C-H, 5HT receptors
- Rx - Cyclizine, Hyoscine, Ondansetron (Zofran)
- **Entero-hepatic** – 5HT₃
- **Vestibular** – Metastasis in skull
- Rx – Required Anti – H₁ or ACH before traveling

Nausea & Vomiting

<p>Causes – 1. Drugs - Opioids, Antibiotics, NSAIDs</p> <p>2. Anxiety or Fear</p> <p><u>Cerebral Sensors</u></p> <ul style="list-style-type: none">-Sight, smell & taste <p><u>Non drug measures</u></p> <ul style="list-style-type: none">-Control malodour-Nice environment –No sight / smell of food-Non exposure to food that may precipitate. nausea.	<p><u>Stress, anxiety & nausea</u></p> <ul style="list-style-type: none">– delayed gastric emptying via peripheral dopaminergic receptors.. <p>Reversible by D2-receptor antagonists-</p> <ul style="list-style-type: none">metoclopramide, haloperidol, Chlorpromazine
<p>Gastritis, Gastric stasis, Functional bowel obstruction</p> <p>Prokinetic agent -</p> <ul style="list-style-type: none">-Metoclopramide- 10mg 4-6hrly, orally/Sc	<p><u>Reversible causes</u></p> <p>Infection, cough, hypercalcaemia, ureamia, Tense ascites, Increase ICP, Anxiety</p>

Nausea & Vomiting

- Primary bowel & pelvic tumors

- Bowel obstruction-N/V early symptom
- Foul smelling feaculent vomit
- Colicky abdominal pain
/constipation – late symptom

Mechanical obstruction

Cyclizine (H₁) + Haloperidol (D₂-Ag)

(Substitute cyclizine with metoclopramide if too sedating)

Enlarged liver metastasis- GOB

- Vomiting of undigested food
- Stomach squashed syndrome

- Pancreatic tumour

- SSS – prokinetic agent – metoclopramide 10mg, 4-6 hrs

Pelvic tumour - Ca ovary

Chemical causes -

- Hypercalcaemia – intractable vomiting
- Morphine, Renal failure

Rx. Halperidol 1-2mg nocte.

-Increase ICP

Headache, worse supine, large projectile vomitus.

Rx. cyclizine 50mg tds orally or 100mg rectally

Other causes of N/V

Bowel obstruction

- Poor prognosis
- Chemo or ascites in the last 6months, hypoalbumaemia, raised urea.

Medical failure -percutaneous endoscopic gastrotomy or NG tube to decompress GIT

- Soft oral diet – Upper GIT absorption.
- Oxterotide-Somatostatin analogue; reduce intestinal secretion volume

Constipation

- 50% of advanced cancer patients on admission
 - Causes
 - local tumour effects
 - reduced fluid & food intake
 - reduced physical activity
 - drugs –opioids, ACH, vincristine,vinblastine – (autonomic neuropathy)
- Rx. -stimulant laxatives –senna liqd
- fecal softener –MgoH2
- Cannabiods – N/V for HIV/AIDS

Choice of drugs

1st line drugs

metoclopramide, cyclizine,
Haloperidol

Long time control –

cyclizine(A-H₁)150-200mg +
Haloperidol 5mg b.d

2nd line drugs-

Hyoscine, dexamethasone

Never prescribe prokinetic drugs with
anti-cholinergics e.g

Metoclopramide + cyclizine or
Hyoscine

CTZ-

- Upper gut receptors-blood and toxins
 - blood borne toxins
 - Opiate- 1/3rd Px. N/V
- Rx .low dose Haloperidol b.d

Phenothiazines - Prochlorperazine (Stemetil)
centrally acting on CTZ dopaminergic

5HT₃ antagonists –Ondansteron
(Zofran)

Rx. severe N/V

- Chemotherapy
- Large doses of Radiotherapy to the
gut.

Chemotherapy

Symptom control agent – pain, dyspnea & others
or symptom inducer (ditto Radiotherapy)

- -N/V - 5HT₃ blockers; granisteron, ondasteron + Dexamethasone
- Hair loss
- Malaise
- Reduced appetite, constipation, diarrhoea
- Emotional distress

Anxiety, depression, disruption of home life,
disturbed sleep, loss of sexual feelings

e.g Cisplatin regimen

Radiotherapy

- Acute problems

- Skin erythema - nil 1%hydrocortisone
- Anxiety, fatigue, lethargy –Assurance

Head & Neck

- alopecia; reassure
- painful mouth, pharynx
- mucositis Rx. soft diet & treat secondary infection like candidiasis

Throat

- Dysphagia (oesophagitis)
Rx. soft diet, analgesics, antacids

- Abdomen/Pelvis

- 1.N/V – prophylaxis stemetil
Intractable - Steroids/Ondansteron

- 2.Diarrheoa

- Low fibre diet –(prophylaxis)
lomotil, imodium (established)

- 3.Dysuria /frequency

- Exclude UTI; m/c/s
- No infection-increase fluid intake

Late effects

- Spinal cord myelitis, lung fibrosis, Chronic Renal Failure.
No Rx.

Ascites

- Causes

PLCC, Breast, Ovary, Colon, Stomach, Pancreas, Bronchus

- Symptoms

-Pain, nausea, vomiting & dyspnea

Rx. Mechanical- Paracentesis

- 2L/24hrs then slowly over 12hrs

Contraindications – gross bowel distension & massive abdominal tumor

- Pharmacological

- diuretics / spironolactone

- PLCC –

- Rx. peritoneo -venous shunt

- Exclude Rt. Ventricular or hepatic failure & abdominal tumour

- Abdominal tumour

- systemic chemotherapy

-intra-peritoneal chemo

- hormone therapy

Other symptoms

- **Lymphoedema**

- Arm – Ca Breast

- Leg – Abdominal tumour

- **Problems**

- pain, disturbed body

- image, anxiety, depression

- **Rx**

1. Skin care – cellulitis (abrasion)

2. Efflurage-(massaging the lymphatics open)

3. Gentle limb exercise

4. Compression bandaging- with gentle external support

Confusion – Delirium

- Diff.dx. Dementia

- **Causes**

Drugs, infection, hypercalcaemia, cardio-respiratory insufficiency (cerebral anoxia)

- **Rx.**

- Haloperidol – agitated delirium

Avoid sedation in patient with unfinished business or affairs.

Other symptoms

- **Hiccup**

- **Causes**

- Phrenic nerve irritation
- Diaphragmatic irritation
- Uremia

- **Rx**

- Pharyngeal stimulation
- Re-breathing into bag
- Drugs - Haloperidol, chlorpromazine, baclofen

- **Death Rattle**

Seen in Terminal patient
esp. in the last few days.

- **Rx**

- Suctioning
- Drying agent -Hyoscine
- Control of dyspnea with low dose morphine

Refractory symptoms

In advance cancer requires sedation

- Prevalence

-Delirium	45%
-N/V	25%
-Convulsion	15%
-Dyspnea	10%
-Pain	5%

- Causes

- Malignant Intestinal. obstruction.
- Extensive bone metastasis.
- Severe jaundice
- Brain metastasis
- GIT bleeding
- Myoclonic jerking

- Rx.

- Medications

- Morphine sulphate 2.5 -5mg 4hrly
- Midazolam – 7.5 -40mg /24hr Sc.
- Haloperidol – 5.0 -10mg/24hr

- Types of sedation

Mild sedation -insomnia, mild anxiety.
(benzodiazepines)

Deep sedation – aimed at loss of consciousness in dying patients.

- Massive heamorrhage
- Massive pulmonary embolism
- Complete airway obstruction

Terminal restlessness

- Causes- Drug toxicity, hypercalcaemia, urine retention
- Faecal impaction – Reversible
- Irreversible situation – sedation
- Deep sedations – (Ethics - Euthanasia??) – ‘Double effect’
- Acronomys
 1. “Terminal sedation”
 2. ‘Sedation for intractable distress in dying’ (*chater et al*)
 3. ‘**Palliative sedation therapy**’ (*morita et al*) – eliminates stigma
 - Sedation could be intermittent or continuous
 - Goal – comfort and caring

Strategies

- Evaluation & re-evaluation
- Explanation to both Pt. & family
- Individualised management.
- Close supervision and monitoring

References

1. David C, Douglas B, Julia B. Use of sedation to relieve refractory symptoms in dying patients. SAMJ June 2004, Vol.94, No 6:445-449
2. Chater S, Viola R, Paterson J, Jarvis V. Sedation for intractable distress in dying: a survey for experts. Palliat. Med 1998;12:255-269
3. Morita T, Tsuneto S, Shima Y. Proposed definitions for Terminal Sedation. Lancet 2001;358:335-336
4. Linda C. Patients' experiences of chemotherapy treatment. Professional Nurse April 1995. Vol.10:7:439-442
5. Claud R, Sam A. Dyspnea in advanced cancer- a flow diagram. Palliative Med. 1990,4;311-315
6. Peter K. The Role of Radiation Therapy in Palliative Cancer. Journal of Palliative Care 11:1:1995;119-126
7. Claud R, Kathryn M. Management of Ascites in advanced cancer- a flow diagram. Palliative Medicine 1989;4:45-47
8. Ilora Finlay. End - of - life Care in Patients Dying of Gynaecologic Cancer. Current Therapeutic issues in Gynaecologic Cancer Vol. 13. Number 1. 1999

Thank you for the attention