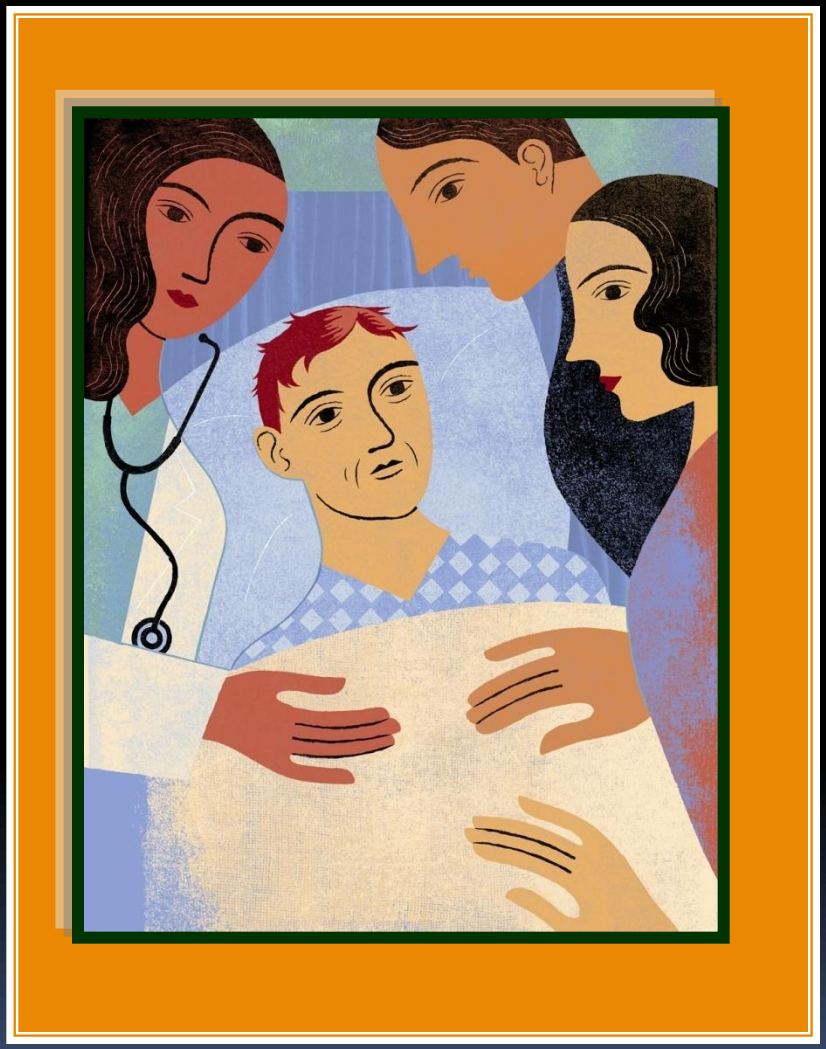


TERMINAL ILLNESS Palliative Care

Dr. Nada A. AL-Yousefi

Assistant Professor and Consultant
Family and Community Medicine Department
King Saud University
nalyousefi@ksu.edu.sa

OBJECTIVES: Terminal Care

1 . To understand the meaning of terminal care

2 . To learn the principles of the Family physician's role in terminal care

3 . To understand the differences in care at home/ hospital and hospice

4 . To learn the management options

Terminal Care

- A 60-year-old lady with history of breast cancer and secondaries in the spine has lot of pain in her back

Q. Which is the single most appropriate analgesic for this patient's back pain?

Terminal Care

- A 65-year-old male with bronchogenic carcinoma and multiple secondaries in the lungs, has persistent distressing cough, which is not responding to usual cough suppressants

Q. Which is the single most effective cough suppressant for this patient?

Terminal Care

- A 57-year-old male with brain tumour has intense headache, which is persistent, and is worse in the mornings, with bouts of vomiting

Q. Which is the single most effective medication for this patient's headache?

Terminal Care

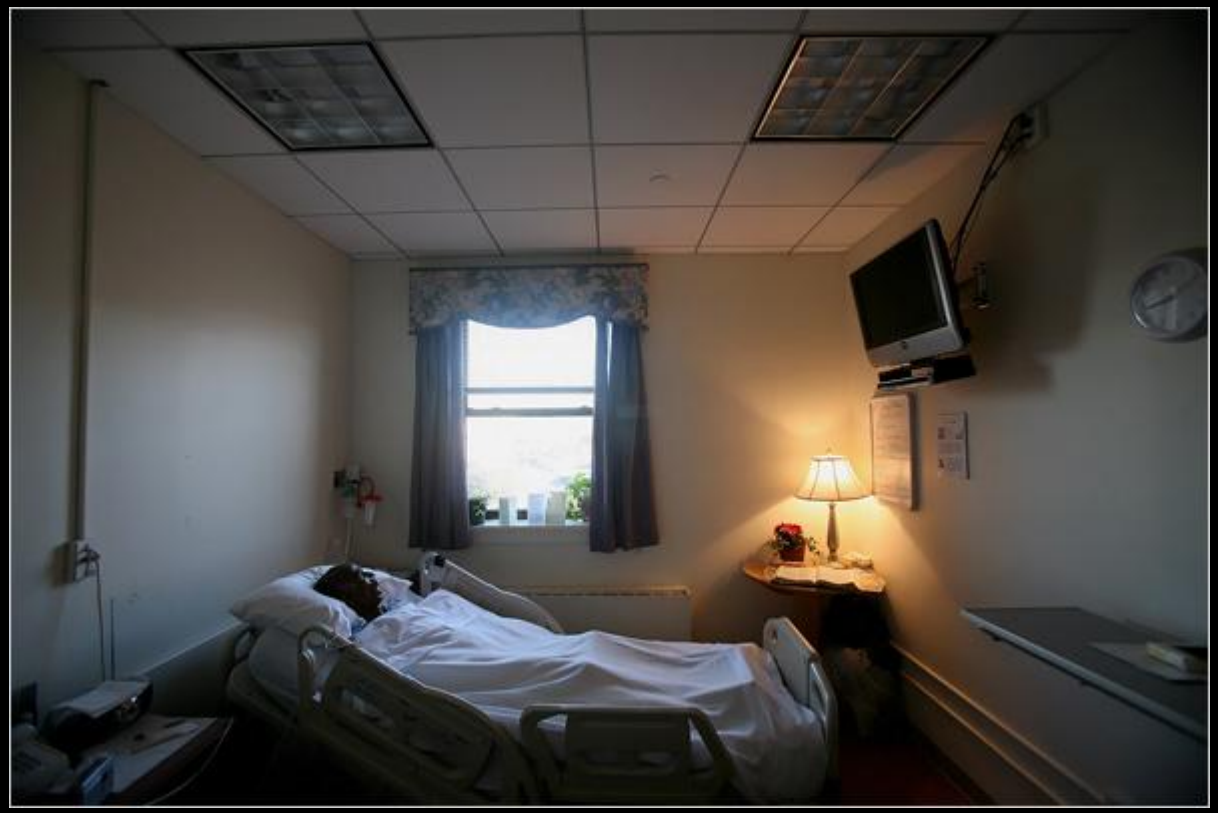
- A 56-year-old male with carcinoma of colon, and multiple secondaries in the spine, has loss of appetite which is not responding to the usual appetite stimulants

Q. Which is the single most appropriate medication to improve this patient's appetite?

Terminal Care

- A 50-year-old smoker attends, for the result of the MRI of his spine. When informed that his previously operated carcinoma of the lung, has now spread to his spine, he bursts out crying and says, "if I had only prayed regularly this would not have happened"

Q. Which is the single most appropriate word for describing this patient's reaction?



END OF LIFE CARE?

- You should consider a patient with a prognosis of less than 12 months as being at the end of their life.

- It is important, but not always easy, to recognise when a patient with non-malignant disease is dying and when the services of a palliative care team will be helpful
- Patients have a better quality of life and survive longer if they receive palliative care
- A range of documents and tools are available to help manage patients in the last 12 months of life, including the National End of Life Care Pathway, the Gold Standards Framework, and the Liverpool Care Pathway.

- One of your patients has been on haemodialysis for some time. They have other chronic conditions, including heart failure and peripheral vascular disease, and they understand that they have terminal disease and a limited life expectancy. When is it appropriate to involve the palliative care team?
  A. Immediately
  B. When the patient starts to deteriorate significantly
  C. When you and the renal team agree that the patient's life expectancy is less than three months
  D. Not until the patient stops dialysis
  E. When the renal team is having difficulty in managing the patient's symptoms

- You see a 70 year old patient with known heart failure who has just been discharged home after her fourth hospital admission in three months. At each admission she has had similar symptoms; mainly an acute exacerbation of her breathlessness. She is tolerating her medication, which includes maximum doses of an angiotensin converting enzyme inhibitor, a beta blocker, spironolactone, and digoxin, and she still seems to be getting some, if limited, benefit from them. Her husband is very worried about her and mentions that she does not appear to be her usual self and seems very low in spirits. What part of the patient's history suggests that she may now need end of life care?

A. She is on maximum doses of all of her drugs
B. The benefit of her drugs is limited
C. Her husband is concerned about her
D. She has had multiple hospital admissions during the last three months
E. Her mood is particularly low

Assess

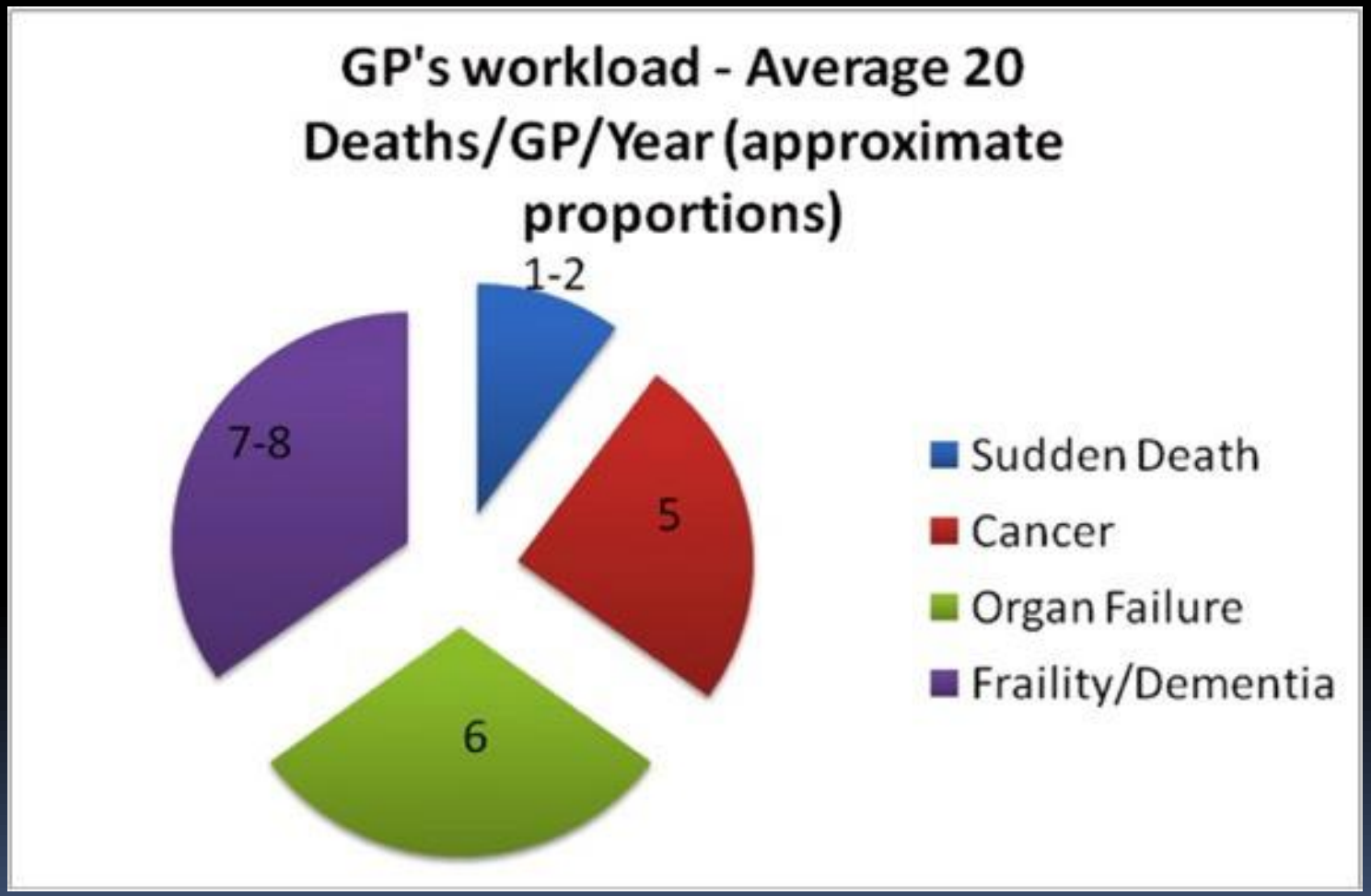
- Having identified your patient as being near the end of their life, assess their current and future clinical, psychological, social, and spiritual needs.
- The aim is to make sure that their management is proactive and not reactive. You can use assessment tools for this, such as the NHS guideline “Advance care planning: a guide for health and social care staff"

Plan

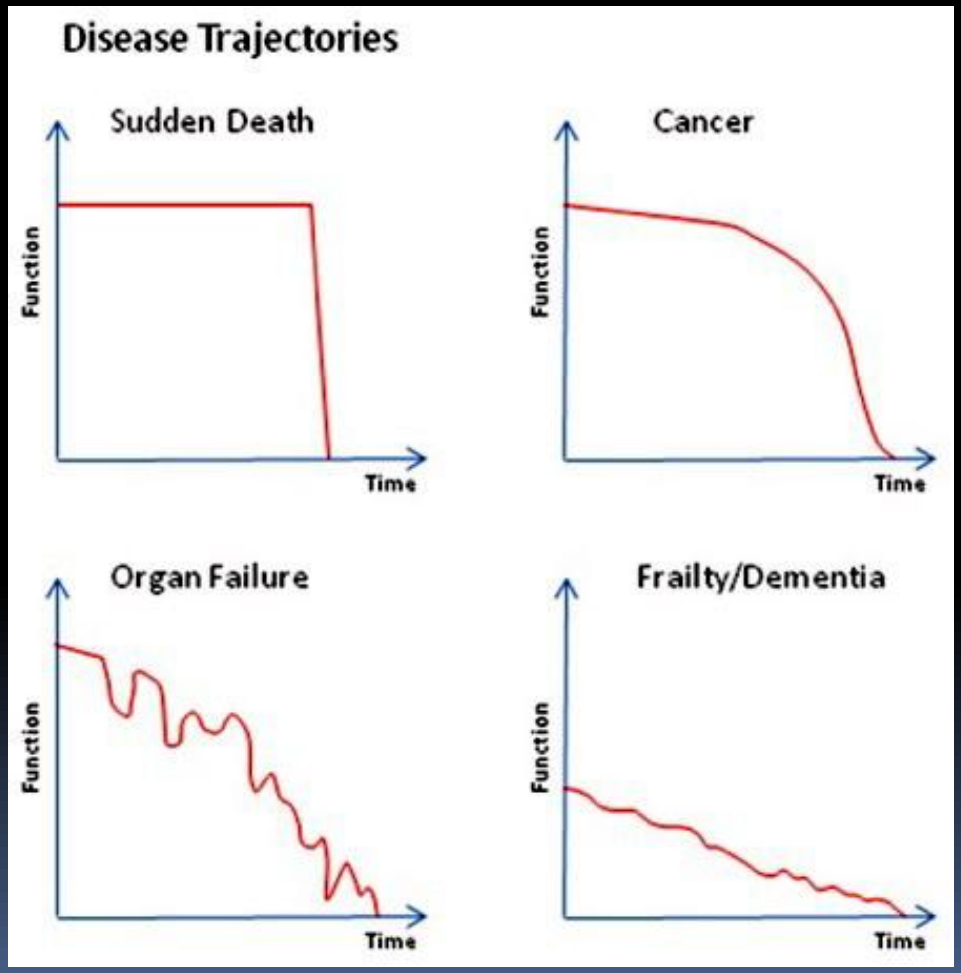
- Develop a plan of care. You may find it useful to use the seven Cs key tasks of the Gold Standards Framework.


7Cs
1
2
3
4
5
6
7
Communication
Coordination
Control of Symptoms
Continuity Out of Hours
Continued Learning
Carer Support
Care in Dying Phase
Advanced Care Plans
Team Planning
Patient
Healthcare team
Liverpool Care Pathway
GSF Key Worker
Healthcare team
Holistic Assessment
Proactive Approach
Handover Form
Anticipatory Prescribing
Learn As You Go
Reflective Practice
Continuous Quality Improvement
Bereavement
Emotional
Practical

GPs workload - the typical split of the average 20 patient deaths per GP per year



Adadpted from: Thomas K. The Gold Standards Framework Centre. Prognostic indicator guidance (revised version 5). September 2008.


Disease Trajectories
Sudden Death
Function
Time
Cancer
Function
Time
Organ Failure
Function
Time
Frailty/Dementia
Function
Time

PRINCIPLES OF A DOCTOR‘S ROLE IN TERMINAL CARE

1. Symptom control and relief.
2. Communication with the patient-never isolate the patient.
3. Avoidance of inappropriate therapy.
4. Support of the relatives.
5. Teamwork-with nurses, social workers, physiotherapists, etc.
6. Continuity of care-regular visiting by the doctor and nurse.

PRINCIPLES OF A DOCTOR‘S ROLE IN TERMINAL CARE

1. Symptom control and relief.
2. Communication with the patient-never isolate the patient.
3. Avoidance of inappropriate therapy.
4. Support of the relatives.
5. Teamwork-with nurses, social workers, physiotherapists, etc.
6. Continuity of care-regular visiting by the doctor and nurse.

I. SYMPTOM CONTROL

- Ensure that the patient and family are aware that pain will be controlled; there is a great fear of pain and a painful death.
- Start analgesia early, regularly and in appropriate dose.
- Do not be afraid of opiates, drug dependency or large doses; give sufficient for the patient's needs.

I. SYMPTOM CONTROL *Cont'd*

- Remember there are other techniques, e.g. nerve blocks. Do not be afraid to consult experts.
- Control other symptoms, e.g. constipation, cough, dyspnoea, insomnia.

II. COMMUNICATION

- Above all give the patient time to talk of his fears and his problems.
- Be honest and truthful if questioned but not pessimistically so.
- A policy of `gentle truth' is generally best.
- Adopt a kind, sympathetic approach; do not be afraid to touch the patient.

II. COMMUNICATION contd

- Respect his religious convictions.
- Never say, `There is nothing more I can do'.
- Don't raise false hopes, but reassure that symptoms will be relieved.

III. AVOIDANCE OF INAPPROPRIATE THERAPY

- Consider the time and question the need for any invasive palliative measures such as intravenous infusions, etc.
- Respect the patient's wishes.

IV. SUPPORT OF THE RELATIVES

- Help the family in caring for and in communicating with the patient ; above all involve them in the patient's care.
- Explain the prognosis and symptomatic treatment clearly.
- Answer their fears and try to alleviate problems. Do not overlook possibilities of financial help.

IV. SUPPORT OF THE RELATIVES- contd

- Give support with nursing problems, etc.
- Try to avoid a `conspiracy of silence' between family, patient and doctor.
- Try to reduce any feelings of guilt within the family by showing understanding.

V. TEAMWORK

- Involve one or more members of the team,

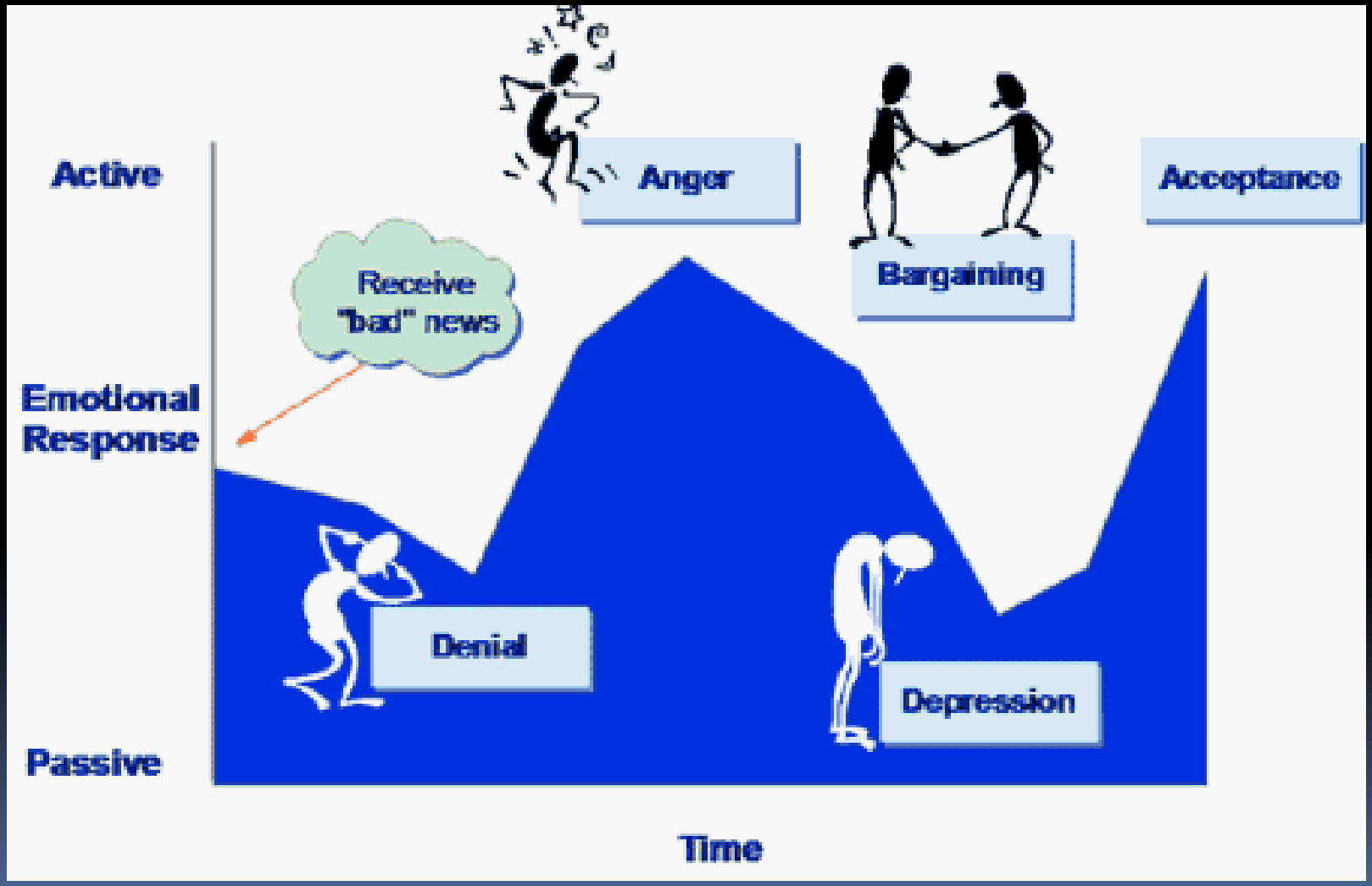
  night nurse, health visitor, home help, occupational therapist, social worker, etc;
- Do not forget an appropriate religious help.

VI. CONTINUITY OF CARE

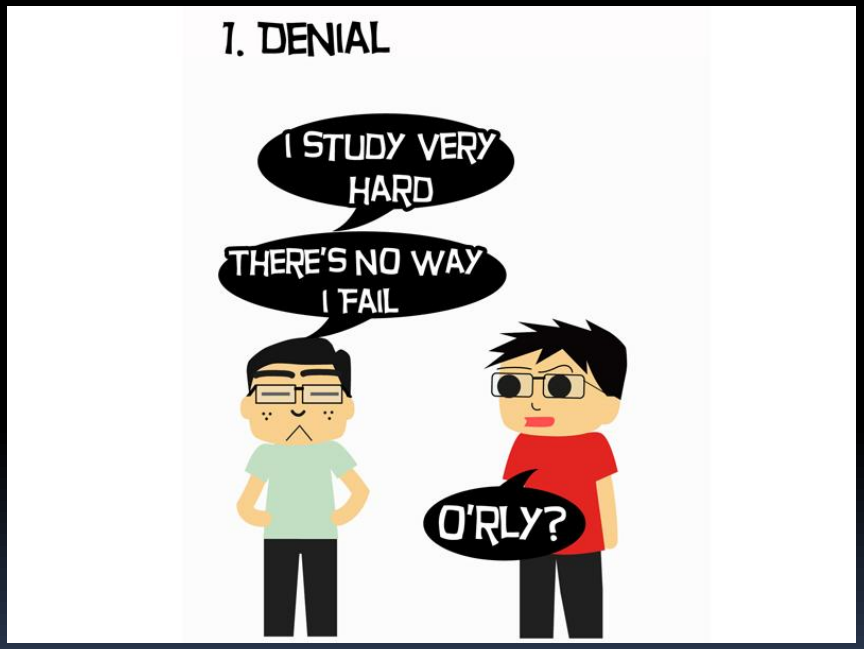
- Ensure that the patient and relatives know that someone will always be available night and day to help, if needed.
- Visit regularly to provide support.
- Do not charge any fee from non-affording patients.

Terminal Care

- What are the problems related to telling the patient the diagnosis and prognosis of his illness?
- What are the patient's likely reactions to the knowledge that he is dying?


Active
Emotional Response
Passive
Time
Receive "bad" news
Denial
Anger
Bargaining
Depression
Acceptance

Denial



- PATIENT/RELATIVES

`It can't be true‘

`It's a mistake

`It's not really happening

- DOCTOR

`It can't happen to my patient‘

Anger

- PATIENT/RELATIVES

'How could this happen to me?'
`What have I done to deserve it?'
' Someone's to blame, probably the doctor'

- DOCTOR

'Why didn't he give up smoking?

'He should have come to see us much earlier'

Bargaining

- PATIENT/RELATIVES

'Perhaps if I had prayed regularly'

'Perhaps if I had taken those tablets'

'Perhaps if I had given up smoking'

- DOCTOR

'How could I have missed the diagnosis?'

'-Perhaps if I had ordered a chest X-ray'

Depression

- PATIENT/RELATIVES

`It really is true‘

`What am I going to do?’

`What is going to happen to my family’

‘I do not matter anymore’

- DOCTOR
- `I’ve got to cope with this‘

Acceptance

- **PATIENT/RELATIVES**

'Life goes on'

'I must prepare for my family'

- **DOCTOR**

'I will look after and care for him in his terminal illness to the best of my ability'

THE ADVANTAGES AND DISADVAN-TAGES OF TRYING TO MANAGE A DYING PATIENT AT HOME

It is not useful to make dogmatic assertions that all patients should die at home or indeed in hospices; much depends on the individual and the circum-stances at the time.

In UK about one-third of patients die at home, two - thirds in hospital and 5% in non-NHS hospitals or hospices.

ANALGESICS IN TERMINAL DISEASE

	ANALGESIC	COMMENTS
Mild Pain	Paracetamol	Use regularly
Mild To Moderate Pain	Various codeine preparations eg.Dihydrocodeine Distalgesic Co proxamol Pentazocine NSAID e.g. Naproxen Radiotherapy may also be considered	Note that pethidine is probably too short-acting to be useful . Pentazocine (Fortral) is also of limited usefulness. If metastases in bone

ANALGESICS IN TERMINAL DISEASE

	ANALGESIC	COMMENTS
Moderate To Severe Pain	Dextromoramide(Palfium)	only adequate for about 2 hours but is useful for exacerbation of pain. In severe pain of any degree resort to morphine.
Severe Pain	Morphine preparations	Oramorph is a useful solution; MST is a sustained-release oral tablet. Diamorphine is for injection.

COMPLEMENTARY THERAPY FOR PAIN :

- Radiotherapy
- Nerve Blocks
- Comfort Techniques
- Physiotherapy
- Relaxation Techniques e.g Hypnosis
- Transcutaneous Electrical Nerve Stimulation
- Acupuncture

1. HOME

Most patients would probably like to die in familiar surroundings. The factors that usually determine whether home care is feasible are :

(A) The patient

- Does he wish to? (some feel they will be too great a burden to their families).

- Are there any important medical needs he can only receive in hospital?

1. HOME

(B) The relatives

- How many are there?
- Do they feel they can cope?
- Can they look after the patient at night?

(C) The services available

- Are night nurses available? Any other Nurses.
- Are bedpans, commodes, etc. available?

2. HOSPITAL

- Care may often fall below desirable levels here for a variety of reasons. Sometimes death is regarded as a failure.

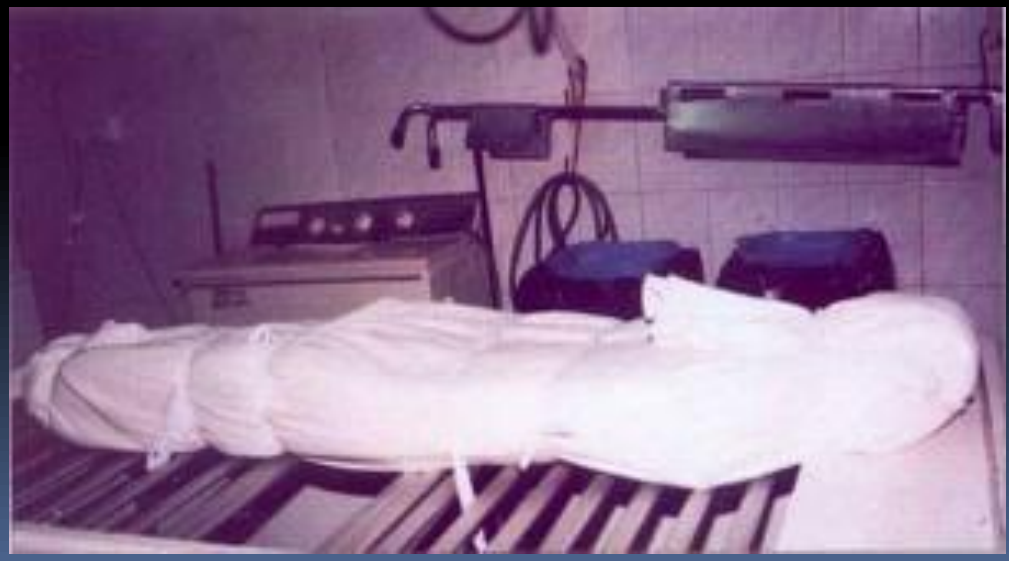
- The staff may be busy. Analgesia should be no problem, but an alarmingly high proportion of patients still die in pain even in hospital

3. HOSPICE/TERMINAL CARE UNIT

The staff are specialists in symptom control and a positive commitment to the patients with an individual approach ensures some of the very best of terminal care.

Following The Death Of The Patient What More Can The Doctor Do?

Home care of the terminally ill is very valuable preparation for bereavement, and at least one study shows that mortality among the bereaved is less if the death occurred at home.



Miscellaneous Conditions

Raised Intracranial Pressure Headache

- Dexamethasone 16 mg oral for 5 days and then 4-6 mg daily.

Intractable Cough

- Morphine 5 mg every 4 hours orally
- Moist Inhalation

Miscellaneous Conditions Cont..

Dyspnoea

- Morphine 5 mg every 4 hours orally
- Diazepam if associated with anxiety 5-10 mg daily
- Dexamethasone 4-8 mg daily if there is bronchospasm or partial obstruction

Excessive respiratory secretion (Death Rattle)

- Inj Hyoscine Hydrobromide 400-600 mcg every 4-8 hours
- Inj S/C Glycopyronium

Mild dyspnoea

Optimise bronchodilators (e.g. SABD and LABD) ± oxygen is appropriate

Increasing dyspnoea

Non- pharmacological measures e.g. pursed lip breathing, fan, relaxation techniques, paced activities ± oxygen is appropriate

Persistent dyspnoea

Palliative Pharmacological measures e.g. morphine dose titration ± anxiolytics ± oxygen is appropriate

Miscellaneous Conditions Cont..

Neuropathic Pain:

- Tricyclic Antidepressants
  - e.g. Amitryptyline
- Anticonvulsants:
  - e.g. Gabapentin, Carbamezapine, Pregabalin

Muscle Spasm Pain

- Muscle Relaxant
  - e.g. Diazepam 5-10 mg daily
  - Baclofen 5-10mg three times daily

Miscellaneous Conditions Cont..

Gastrointestinal Pain:

- Hyoscine Hydrobromide (Buscopan) 20 Mg four times daily
- Loperamide especially with Diarrhea

Gastrointestinal Distension Pain:

- Antacid plus Domperidone (Motillium) 10 mg TDS

Dysphagia:

- Dexamethasone 8 mg daily

Miscellaneous Conditions Cont..

Constipation:

- Fecal Softener with Peristaltic Stimulant eg Co-Danthramer /Bisacodyl (dulcolax)

Anorexia:

- Dexamethasone 2-4 mg daily
- Prednisolone 15- 30 m daily

Nausea And Vomiting:

Ideally cause should be identified

- Haloperidol 5 mg once or twice daily
- Metaclopromide 10 mg TDS

_ Cyclazine 50 mg TDS

Miscellaneous Conditions Cont..

- Dry Mouth
  - Sucking Ice
  - Pineapple Chunks
  - Artificial Saliva
- Pruritis
  - Application of Emollients e.g. Calamine Lotion
  - Application of Aqueous Cream, petroleum Jelly
  - Antihistamine
  - Steroids
  - Cholestyramine in obstructive jaundice

Miscellaneous Conditions Cont..

Restlessness and Confusion:

- Haloperidol 1-3 mg every 8 hours orally
- Risperidone 1 mg twice daily
- Chlorpromazine 25-50 every 8 hourly

Hiccups:

- Antacid with Domperidone or Metoclopramide 10 mg every 6-8 hours
- Nifedipine 10 mg TDS
- Chlorpromazine 25 mg TDS

CONCLUSION

- Terminal care at home is one of the most important areas of Family Practice
- Analgesia must be regular and appropriate. Morphine is best for severe pain
- A kind, caring approach by the doctor is as beneficial as the medication he prescribes
- The care of the grieving relatives :

  terminal care does not end with the death of the patient