PHC

432 Team

9 Terminal Illness - Palliative Care

Done By:
Abdulaziz Fahad Bin Yahya

Reviewed By:
Ibrahim alqasir

جامعة
الملك سعود
King Saud University

COLOR GUID: Doctor's Notes Team Notes slides Not important Important 431 team work

Objectives

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 some of the management options.

Definition of Terminal Care:

- Care of a patient whose disease is incurable and he/she is terminally ill.
- The aim is to make the dying patient's remaining period of life as comfortable as possible.

Do Saudi patients want to know, if they have Cancer?

An Eastern Province Study:

113 out of 114 patients wanted to know the full information

Medical students study:

92. 8 % of males and the same percentage of female students wanted to know the full information

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.

Q: What is the maximum dose of analgesic patient with terminal illness can be given? Answer: There is no upper limit. Give as much as the patient needs to stop the pain.(Important!)

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.

#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.

#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 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.(But never give estimate of how much the patient has got to live!) ‘Important’

#Answer their fears and try to alleviate problems. Do not overlook possibilities of financial help.

#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.

- 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?

The stages are very important

STAGES	PATIENT/RELATIVES	DOCTOR
1. Denial	\`It can't be true'   \`It's a mistake \`It's not really happening	\` It can't happen to my patient\`
2. Anger	'How could this happen to me?' \`What have I done to deserve it?' ' Someone's to blame, probably the doctor'	'Why didn't he give up smoking? 'He should have come to see us much earlier'
3. Bargaining	'Perhaps if I had prayed regularly' 'Perhaps if I had taken those tablets' 'Perhaps if I had given up smoking'	'How could I have missed the diagnosis?' '-Perhaps if I had ordered a chest X-ray'
4. Depression	\`It really is true'   \`What am I going to do?' \`What is going to happen to my family' 'I do not matter anymore'	\` I've got to cope with this\`
5. Acceptance	'Life goes on' 'I must prepare for my family'	'I will look after and care for him in his terminal illness to the best of my ability'

THE ADVANTAGES AND DISADVANTAGES OF TRYING TO MANAGE A DYING PATIENT AT HOME:

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

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

ANALGESICS IN TERMINAL DISEASE:

	ANALGESIC	COMMENTS
Mild Pain	**Aspirin or Paracetamol**	**Use regularly**
Mild To Moderate Pain	**Various codeine preparations eg.Dihydrocodeine Distalgesic** **Co proxamol**	**Note that pethidine is probably too short- acting to be useful.**
Moderate To Severe Pain	**NSAID e.g. Naproxen Radiotherapy may also be considered** **Dextromoramide (Palfium)**	**If metastases in bones.** **Only adequate for about 2 hours, but is useful for exacerbation of pain.**
Severe Pain	**Morphine preparations** (The only effective medication in severe pain) 'Important'	**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 aburden to their families).
- Are there any important medical needs he can only receive in hospital?

(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

N.B. Hospice: A specialised centre in which trained team of health care professionals provide terminal care for

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.(Terminal care should not end after the death of patient, care of the grieving relatives is very important as well.)

Miscellaneous Conditions : very important

Hint :Dr yousef Al turki said dosage is not important in PHC

- These medications might not be indicated in other normal patients and can only be given in case of terminal illness (No need to know the dosage, just the names)

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

Dyspnoea

- **Morphine** 5 mg every 4 hours orally
- Diazepam if associated with anxiety 5-10 mg daily
- Dexa-methasone 4-8 mg daily if there is broncho-spasm or partial obstruction

Excessive respiratory secretion (Death Rattle)

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

Neuropathic Pain:

- Tricyclic Antidepressants
  - e.g. Amitryptyline
- Anticonvulsants:
  - e.g. Gabapentin, Carbamazepine, Pregablin

Muscle Spasm Pain:

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

Gastrointestinal Pain:

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

Gastrointestinal Distension Pain:

- Antacid plus Domperidon (Motilium) 10 mg TDS

Dysphagia:

- Dexamethasone 8 mg daily

Constipation:

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

Hiccups:

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

Anorexia:

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

Nausea & Vomiting:

Ideally cause should be identified

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

_ Cyclazine 50 mg TDS

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

Restlessness and Confusion:

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

Summary

#Terminal care at home is one of the most important areas of Family/ Community 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.

Questions

1) A 60-year-old lady with history of breast cancer and secondaries in the spine has lot of pain in her back. Which is the single most appropriate initial analgesic for this patient's back pain?

a. NSAIDS
b. Morphine
c. Prednisolone
d. Dexamethasone

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

a. Morphine
b. prednisolone
c. NSAIDS
d. Dexamethasone

3) A 57-year-old male with brain tumour has intense headache, which is persistent, and is worse in the mornings, with bouts of vomiting Which is the single most effective medication for this patient's headache ?

a. Dexamethasone
b. prednisolone
c. NSAIDS
d. Morphine

4) 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 Which is the single most appropriate drug to improve this patient's appetite ?

a. Dexamethasone
b. prednisolone
c. NSAIDS
d. Morphine

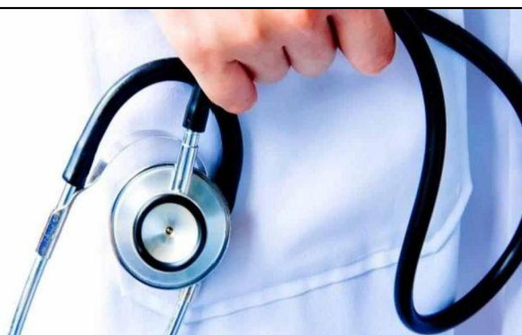
5) A 50-year-old smoker attends, for the result of the MRI of his spine. When informed that his previously operated carcinoma of the lung, has now spread to his spine, he bursts out crying and says, "if I had only prayed regularly this would not have happened. Which is the single most appropriate 'word' for describing this patient's reaction?

a. bargaining
b. Depression
c. Acceptance
d. Denial

432 PHC Team Leader

Yazeed A. Alhusainy

phcteams@gmail.com



Answers:

1st Questions:A

2nd Questions:A

3rd Questions:A

4th Questions:A

5th Questions:A