

17. HOME-BASED CARE AND CONTROL OF COMMON SYMPTOMS

Control of symptoms at all stages of HIV/AIDS will improve quality of life. When treating symptomatically, always remember that opportunistic infections (OI's) occur often and may need specific treatment. Refer to the relevant chapter.

17.1 Respiratory system

It is important to identify the cause of the symptom and to treat it. The following sections describe the management of common symptoms related to the respiratory system.

17.1.1 Management of cough

Dry cough

Cough suppressant treatment - codeine 15 - 30mg four to six hourly, (codeine is a mild anti-tussive), or morphine start with 2.5 - 5mg 4 hourly and increase as necessary

Bronchodilators – salbutamol, inhaled or nebulized, 5mg 4 hourly, oral 2 – 4mg tid, or steroids, prednisolone 30 – 40mg daily (also useful for bronchospasm)

Non pharmacological methods eg. radiotherapy, pleural aspiration and pleurodesis

Productive cough

Mucolytics, such as, cough mixtures (eg. Flemex which contains carbocysteine 250mg/5ml, use 10 – 15 ml tid), or nebulized acetylcysteine to loosen tenacious sputum, or steam inhalation – loosens tenacious sputum, or nebulized saline – loosens tenacious sputum

Hyoscine – dries secretions - 0.4mg im, 1.2 – 3.6mg sc/24hrs

Antibiotics – if purulent sputum; use metronidazole for halitosis or foul-smelling sputum

Diuretics – for heart failure

Nursing

- Position which is most comfortable for the patient- often propped up on 2-3 pillows in a semi-recumbent position
- Physiotherapy - gentle percussion, forced expirations, postural drainage, breathing exercises
- Reassure, use a table fan, open windows and doors, discourage smoking around the patient

Refer patient if:

- Distressing cough continues
- Fever develops
- Haemoptysis is severe and persistent
- Distressing dyspnoea continues

17.1.2 Management of breathlessness

- Dyspnoea is extremely frightening and panic will worsen it (patients imagine suffocating to death) - reassurance and explanation will help.
- Morphine - start with 2.5 - 5 mg 4 hourly (or increase the dose currently used for pain.
- Steroids - prednisolone 40 - 60mg daily reduces bronchospasm, peri-tumour oedema
- Bronchodilators - nebulized salbutamol 2.5 - 5mg 4 hourly
- Anxiolytics - diazepam 2 - 10mg or lorazepam 0.5 - 1mg nocte, prn or tid
- Oxygen - be careful of inducing oxygen dependence

Nursing care

- Reassurance and relaxation techniques

- Physiotherapy - breathing exercises
- Position which is most comfortable for the patient

17.1.3 Management of pleural effusion

Asymptomatic

- No specific treatment

Symptomatic

- Analgesics for pain control
- Treatment for cough and breathlessness
- Aspirate for relief of breathlessness (1 - 1.5 L should be removed and repeat as necessary)
- **NB. Tapping may increase the rate of fluid accumulation.**
- Consider pleurodesis with bleomycin for recurrent malignant effusions (40 - 60mg in 100ml saline with 20ml 1% lignocaine after drainage to dryness)

17.1.4 Superior vena caval obstruction

- Radiotherapy with steroid cover
- Chemotherapy - for responsive tumours
- Dexamethasone 8 - 12mg daily (iv dexamethasone 20mg for emergency treatment)
- Oxygen 100% - for emergency treatment
- Frusemide 40 - 80mg for emergency treatment

17.1.5 Haemoptysis

- Reassurance
- Radiotherapy controls haemoptysis in 90%
- Transfusion if symptomatic anaemia develops

17.1.6 Stridor

- Steroids dexamethasone 8 - 12mg daily, short course
- Local radiotherapy
- NB radiotherapy may worsen stridor initially as a result of tissue oedema; use steroids or chemotherapy initially if possible
- Chemotherapy if sensitive tumour

17.1.7 Hiccups

- Identify and treat the cause if possible
- chlorpromazine 5 - 25mg tid prn (use syrup 50mg in 5ml)
- metoclopramide 10mg tid orally

17.2 Gastrointestinal system

17.2.1 Management of oral ulcers / sore mouth

Refer to chapter on oral manifestations.

Nursing care

- Instruct patient in oral care - use soft toothbrush, clean mouth with dilute solution of salt or bicarbonate three or four times daily and at bedtime
- Diet - soft diet, textured food, avoid very hot or cold or spicy foods
- Dry mouth - suck on ice, pineapple or citrus fruit

17.2.2 Management of anorexia

- Treat the cause if possible; often secondary to intercurrent illness. Altered taste sensation may be a problem

- Metoclopramide 10mg tid before meals
- Steroids - prednisolone 10 - 30mg daily for 1 - 2 weeks may help, then withdraw
- Multivitamins may help use 1-2 tablets daily

Nursing care

- Eat small amounts frequently and when hungry
- Help patient to sit up at meal times and eat with others
- Eliminate odours
- Maintain fluid intake
- Use food supplements if affordable (sip feeding 50-100ml hourly)17.2.3

17.2.3 Management of nausea and vomiting

Many therapies may induce nausea. Identify the reason for nausea and treat the cause if possible.

- Anti-emetics - for prevention of nausea - use **oral** prochlorperazine 5 - 10mg tid, metoclopramide 10mg tid, cyclizine 50mg tid or haloperidol 1.5mg nocte. For established nausea, use **im** route eg. prochlorperazine 12.5mg or cyclizine 50mg or metoclopramide 10 mg, or **rectal** route eg. cyclizine suppositories 50mg tid if medication available and then convert to oral route, or **SC infusion** with a syringe driver eg metoclopramide 60mg per 24hrs, cyclizine 150mg per 24 hrs, or haloperidol 5mg per 24 hrs in frail patients. SC infusion may also be used for severe nausea and vomiting.
- Steroids - consider use of dexamethasone - 4 to 8mg per 24hrs

Nursing care

- Eat small amounts
- Choose foods that the patient likes
- Maintain fluid intake - sip cold clear liquids slowly and give oral rehydration solution made up as follows: 750ml boiled cooled water, Plus 6 teaspoonfuls of sugar, Plus half teaspoonful salt

17.2.4 Diarrhoea

Many cases of diarrhoea have a treatable cause. Refer to Chapter on GI manifestations of HIV disease

Identify and treat cause. Remember that drugs can induce diarrhoea and that spurious diarrhoea may occur in persons with severe chronic constipation. Diarrhoea may be treated as follows:

- loperamide 2 - 4 mg qid, Or
- codeine 30mg tid to maximum dose of 60mg 4 hourly, And
- antibiotics if indicated
- morphine start with 5mg 4 hourly orally

Nursing care

- Encourage oral fluids and use oral rehydration solution
- Use cooked starchy food
- Careful care of perianal area to prevent skin problems - clean and dry well after each bowel movement, sit in a bowl of warm, clean water, inspect area, water repellent cream locally
- Refer patient if:
 - Fever develops
 - There is blood in the stool
 - Vomiting develops as well as diarrhoea
 - There is severe dehydration or low potassium
 - If there is severe malnutrition

17.2.5 Constipation

Poor food and fluid intake and poor general health are common causes of constipation. Drugs such as codeine and opioids lead to constipation and when such drugs are used the patient may require concomitant use of laxatives unless the patient is already liable to diarrhoea. Constipation may be managed as follows:

- Liquid paraffin (softener) 10 - 15ml nocte
- Laxatives - bisacodyl (stimulant laxative) 2 - 4 tablets nocte
- Glycerine suppository - can be used with bisacodyl

Nursing care

- Ensure adequate fluid intake and correct dehydration
- Encourage a high fibre diet
- May need manual removal of stool
- May need enema

17.3 Genitourinary system

17.3.1 Urinary incontinence

Look for a treatable cause eg. infection, urinary retention and correct this

Nursing

- In males - use peniflow, skin care, eliminate odours (frequent emptying of bag), catheterization
- In females, use of incontinence pads/sanitary towels, catheterization
- General hygiene and instruct family about catheter care

- Very frail patients may need simple measures like a bottle/bedpan at the bedside

17.3.2 Urinary retention

Identify and treat cause, the condition may be due to drugs such as, anticholinergic drugs, tricyclic antidepressants and occasionally opioids. Most patients will require catheterization initially.

17.3.3 Vaginal and urethral infections

Identify cause if possible and treat according to guidelines given for the management of STIs.

Nursing care

- Keep perineum clean with weak saline or bicarbonate solution
- Use natural yogurt on a sanitary pad to get rid of smell

17.4 Central nervous system

17.4.1 Insomnia

- Assess cause and treat appropriately, note that drugs may cause insomnia
- Nitrazepam 2.5 - 5mg nocte or lorazepam 0.5 - 1mg nocte (anxiolytic)
- Amitryptiline 25 - 50mg nocte (sedative anti-depressant)
- Chlorpromazine 25 - 50mg if intractable insomnia

Nursing care

- Often reassurance and talking to the patient helps

17.4.2 Leg cramps

- Quinine 300mg nocte for up to 4 weeks
- Diazepam 5 - 10mg nocte prn

17.4.3 Confusion

Identify and treat cause. Drugs often cause confusion. Therefore, remove the offending drug. Add a drug only if the patient needs calming or sedation and choose the drug according to the degree of sedation required.

- trifluoperazine 1 - 2mg tid
- haloperidol 1.5 mg bd
- chlorpromazine 25 - 50mg tid

Nursing care

- Keep the environment familiar
- Speak normally and in short simple sentences
- A clock and calendar may help orientation
- Ensure that patient is escorted wherever he/she goes
- Do not restrain physically

17.4.4 Depression

See CHAPTER ON NEUROPSYCHIATRIC MANIFESTATIONS

17.4.5 Anxiety

See CHAPTER ON NEUROPSYCHIATRIC MANIFESTATIONS

17.4.6 Weakness

- Identify cause and treat if feasible
- Always provide explanation and emotional support

- Provide occupational therapy
- Arrange for physiotherapy
- If severe anaemia, Hb < 6.0gm/L, give blood transfusion. Note that transfusions only have a short-lived effect
- Multivitamins use 1- 2 tablets daily (placebo effect)
- Steroids (eg dexamethasone 2 - 4mg daily) may improve well-being rather than physical strength though there is a risk of proximal myopathy. Discuss with the doctor first.

17.5 Skin problems

See **SKIN CHAPTER**

17.5.1 Itching

- Avoid scratching
- Keep skin cool and encourage clean, loose clothing
- Use petroleum jelly to prevent dryness
- Anti-pruritic drugs

17.5.2 Ulcers/wounds/tumours

- Clean with salt solution (1 teaspoon salt in 1L cool boiled water) or betadine
- If infected, use icing/brown sugar paste on ulcerated areas and tumours
- If smelly and infected, use metronidazole powder on ulcerated areas or tumours
- Give antibiotics

17.6 The dying patient

Most patients prefer to die at home.

What to do:

- Prepare the family for death but do not predict an exact time
- Check that the family can cope with the dying patient at home and refer to hospital if the family is unable to cope.
- If the patient wishes, he/she should be allowed to go to his/her rural home in order to die there.
- Continue nursing care as appropriate.
- Counsel the family and the patient - this is a time to let go and to say good-bye

17.7 Bereavement, grief and loss

The caring support of those willing to listen to their experience of grief is most important to the bereaved. When a terminal illness is diagnosed the family begins to grieve. While caring for the needs of the patient the carer has to think about a future after the person dies. This is called anticipatory grief and can be a confusing and difficult time.

It is important that family members do not detach from the dying person before death occurs as this will result in abandonment and loss of care. It is useful when family members visit to remain with the patient as the disease progresses and death draws near.

What to do:

- At the time of death allow family members to stay with the deceased for a while.
- Do not refer to the deceased as "the body", but by their name.
- If the family were not present at the death give as much detail as possible.
- Involve children and allow them to express their feelings.
- Allow feelings, e.g. crying, shouting, wailing, both at the time of death and later.

- Allow repetition of the story of the illness and death. Encourage the bereaved to talk about their experience.
- Encourage family members to talk to each other and to share feelings, such as guilt, relief, pain or anger.
- Listen rather than talk.
- Discourage a bereaved person from making big decisions, e.g. change of job, home, town. Sometimes changes are a way of escaping from painful thoughts and feelings.
- Be aware that your own grief may affect your communication with others.
- Some practices and rituals can be helpful, e.g. the telling of the story many times to the mourners.

What **not** to do:

- Do not tell the person what they should do and what they should not do.
- Do not say you know how the other person feels because every experience is unique
- Do not tell your own experience.
- Do not make a bereaved person feel you are in a hurry.
- Avoid euphemisms e.g. "God only takes the best" or "time will heal" as the bereaved do not find them useful.

There is no specific time when grief should end. Each loss is different and specific for the individuals concerned.

See CHAPTER ON PSYCHOSOCIAL CARE AND SUPPORT