

18. PALLIATIVE CARE

18.1 Introduction

Palliative care is a philosophy of care that combines a range of therapies with the aim of achieving the best quality of life for patients who are suffering from life threatening and ultimately incurable illness. Central to this philosophy is the belief that everyone has a right to be treated and to die with dignity and that the relief of pain – physical, emotional, spiritual and social - is essential to the process. In order to enhance quality of life all symptoms including pain need to be addressed.

Palliative care ideally combines the professionalism of a multi-disciplinary team that includes the patient and his family. It should be provided both in hospitals and in the community – that is, there should be a continuum of care. This care should continue from diagnosis and throughout a patient's illness and death and it should extend to the family during the period of bereavement.

18.2 Principles of palliative care

The goal is the provision of the best possible quality of life. The principles include:

- Reinforcing life and accepting that dying is a normal process.
- Death is neither hastened nor postponed.
- Palliative care extends throughout an illness from diagnosis to death.
- Normal medical treatment continues. Investigations are kept to a minimum
- Providing a support system for the patient and for the family that is easily applicable in a home care situation.
- Palliative care usually requires teamwork.
- Advance planning is preferable to crisis management.

18.3 Classification of pain

Pain may be nociceptive or non-nociceptive:

- Nociceptive - due to stimulation of pain receptors in afferent nerves
 - somatic - involving skin, soft tissue, muscle, and bone
 - visceral - involving internal organs and hollow viscera
- Non-nociceptive or neuropathic

18.4 Aetiology of pain in AIDS

Pain in AIDS may be:

- related to the HIV/AIDS or to the consequences of immunosuppression (45%)
- related to HIV/AIDS therapy (15-30%)
- unrelated to AIDS (25-40%)

Many patients have multiple sources of pain

18.5 Principles of management

Pain is a dual phenomenon:

- perception of pain
- emotional response to pain

Optimal management requires a multi-disciplinary approach that depends on the patient's pain threshold level:

Factors that reduce threshold of pain:

- Insomnia, fatigue, fear of dying, anger, boredom, abandonment

Factors that raise the threshold of pain

- Relief of pain and symptoms, sleep/adequate rest, sympathy, reduction of anxiety, companionship, diversion

18.6 Categories of Pain

- physical
- psychological
 - emotional
 - social
 - spiritual

18.6.1 Physical pain

Physical pain in AIDS patients is a clinically significant problem. About two thirds of patients complain of pain at some time during their illness. Pain is invariably accompanied by other symptoms.

Assessment

- Assess all patients for pain at every visit or contact

Diagnose the pain

- assess location (see diagram of body chart)
- severity (see pain scales)
- quality
- onset and duration
- timing
- alleviating and aggravating factors
- interference with daily life
- associated symptoms
- if possible determine the cause of the pain - for new pain and any change in pain.

Treat the pain

- With analgesics
- With adjuvant medication for specific problems
- With non-medical treatments

18.6.2 Psychological painMental/emotional pain

This involves mostly symptoms of anxiety related to:

- Fear of pain and suffering
- Fear of death and dying
- Anger at the illness and the failure of treatment to cure it

Management

Active counseling and /or appropriate referral for psychosocial support

Social pain

This involves dealing with loss:

- Loss of job and income
- Loss of position in the family
- Loss of effectiveness in the community, of status
- Loss of body image

Management

Active counseling and/or appropriate referral for psychosocial support

Spiritual pain

This involves questioning the meaning of life and the significance of the illness.

There may or may not be a religious dimension and this needs specific counseling and support. Active counseling is needed.

18.7 Analgesics

Analgesics should be prescribed rationally. The main objective of analgesic therapy is to provide pain relief without producing unwanted side effects. It is important to adhere to the following principles in managing chronic pain:

By the mouth

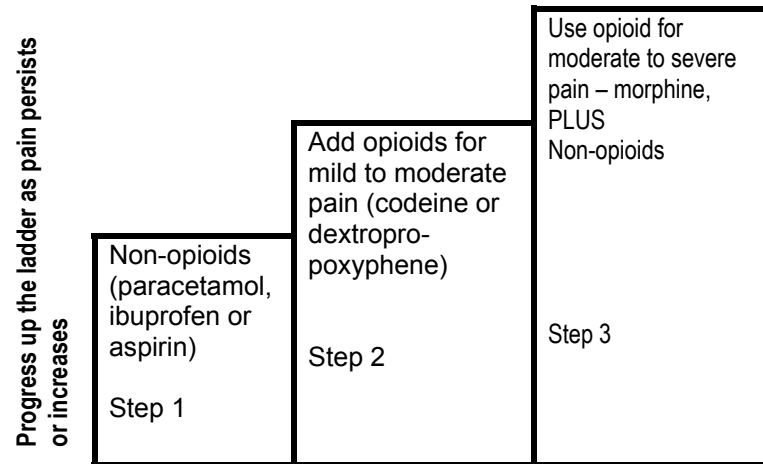
Use oral medication where possible

By the clock

Give painkillers at fixed time intervals. The next dose should happen before the effect of the previous dose wears off. Use extra doses (50-100% of the four-hourly dose) if breakthrough pain occurs

By the ladder (see Figure 18.1)

Figure 18.1



Mild pain – non-opioid

Moderate pain – weak opioid plus non-opioid &/or adjuvant

Severe pain – strong opioid plus non-opioid &/or adjuvant

Individualize treatment

Titrate the dose against patient's pain

Teach the patient and the family how to administer the drugs

Write out the drug regime in full or make a chart

Link the first and last doses to waking and sleeping times

ANALGESIC	USUAL STARTING DOSE	RANGE	SIDE-EFFECTS / DISADVANTAGES
Non-opioid			
Paracetamol	500mg – 1gm (1 – 2tabs) every 4 – 6 hrs		should not exceed 8 tablets in 24 hours
Opioids for mild to moderate pain+			
Codeine	30 mg every 4 - 6 hours	30-60mg every 4-8 hrs	Constipation Cost
Dextropoxyphene*	65mg 4 – 6 hrly	65 – 130mg every 4 hrs (1 – 2 tabs)	Drowsiness Ceiling dose
+Do not move from one weak opioid to another *Doxypol contains paracetamol 300mg and dextropoxyphene 65mg per tablet			
Opioids for moderate to severe pain			
Morphine	5 – 10 mg every 4 hrs	according to need, no ceiling dose – increase dose by 50% in 24 hrs if not pain-free	Constipation

18.7.1 Side effects of morphine or other opioidsConstipation

Prevent by using regular laxatives routinely. Give liquid paraffin 15-45ml once or twice daily & stimulant laxative and increase fluids and bulk in diet.

Nausea

Prevent by using anti-emetics for 3-5 days. This occurs in approximately 30% of patients in the first three days.

Respiratory depression

Unlikely to occur if doses started at appropriate level. Caution with frail or dehydrated patients.

Confusion/drowsiness

Usually resolves within a few days of starting morphine. Can occur at the end of life with renal failure; reduce the dose.

Itching

This is usually temporary and responds to antihistamines. It is not necessarily an allergic reaction

Sleepiness

If persists two days after starting regular morphine reduce the dose

Twitching

Consider reducing the dose. This may indicate toxicity.

18.7.2 How to reduce morphine when cause of pain is controlled

- If only on for a short time: stop or rapidly reduce
- If on for longer than 3 weeks: reduce gradually to avoid withdrawal symptoms

18.7.3 Routes of administration of morphine

Morphine can be used by various routes:

- Oral
- Subcutaneous (using a syringe driver)
- Rectal (unreliable absorption)
- Intra-venous
- Intra-spinal
- Intra-muscular

Routes of administration most commonly used are oral, sub-cutaneous or intra-muscular.

There are specific indications for using these alternative routes.

Other opioids eg. Fentanyl can be used transdermally.

18.7.4 Addiction, tolerance, dependence

In practice tolerance seems not to occur. An increase in morphine requirement usually means increase in the tumour mass. Physical dependence does occur after 2-3 weeks of regular morphine administration; if it is possible to remove the cause of the pain, (as often occurs in AIDS patients) the patient can be weaned off the morphine. Psychological dependence (addiction) has not been observed to happen in cancer patients.

18.8 Adjuvant drugs (co-analgesics)

These enhance analgesic efficacy of opioids, provide independent analgesia and treat concurrent symptoms that exacerbate pain.

- Non steroidal anti-inflammatory drugs (NSAID's) - useful for bone, joint and soft tissue pain. Use ibuprofen (200 - 400mg eight hourly) or aspirin (300 - 600mg 4 to 6 hourly). AIDS patients may have more toxicity from NSAID's including gastric ulceration, renal impairment, liver dysfunction, bleeding as a result of inhibition of platelet function. Prophylaxis for NSAID related GI symptoms includes taking tablets with food or antacids.
- Anti-depressants - used for neuropathic pain. Use low dose amitriptyline (12.5 - 25mg nocte), wait 2 weeks for response and then increase gradually to a maximum of 75mg nocte. Carbamazepine can be used (start with 200mg nocte and increase gradually to 200mg - 400mg bd, max dose 400mg tid) but with caution in AIDS patients who have low platelets; it is also more expensive than amitriptyline.
- Antibiotics - for infection of soft tissues. Drugs most commonly used include chloramphenicol 500mg qid, metronidazole 400mg tid or cloxacillin 500mg qid.
- Corticosteroids - used for raised intracranial pressure (dexamethasone 12mg daily in divided doses for a week), swelling

around a tumour, nerve compression (8mg daily). Use prednisolone in equivalent doses if dexamethasone is not available (dexamethasone 1mg = prednisolone 7.5mg).

- Diazepam - for muscle spasm. Use 5 - 20mg nocte.

18.9 Other modalities of treatment

- Radiotherapy - may be used to reduce bone pain, soft tissue pain, cerebral metastases
- Chemotherapy may be used palliatively.
- Nerve blocks can be used for localized pain
- Surgical procedures may be helpful
- Hormone therapy is used in certain tumours

18.10 Non-pharmacological interventions

- Emotional support - listening, counseling, expressive therapies support groups, relaxation techniques
- Physical methods - massage, exercise, touch, hot or cold compresses, acupuncture.

18.11 Specific pain syndromes in HIV/AIDS patients

- oropharyngeal pain
- oesophageal pain
- abdominal pain
- biliary tract and pancreatic
- anorectal
- chest pain syndromes
- headache

- neuropathies
- arthritis and arthropathies
- myopathy and myositis

IMPORTANT POINTS:

- Listen to the patient and answer questions honestly
- Do not be afraid to talk about dying and preparing for death.
- Every patient is different and has different coping mechanisms with illness and dying
- Don't talk down to the patient, or treat them as if they were children
- Hope is an important part of living even when dying but it must be balanced against reality. Hope can be re-defined e.g. for a pain-free existence as opposed to cure, and ultimately for a peaceful death.