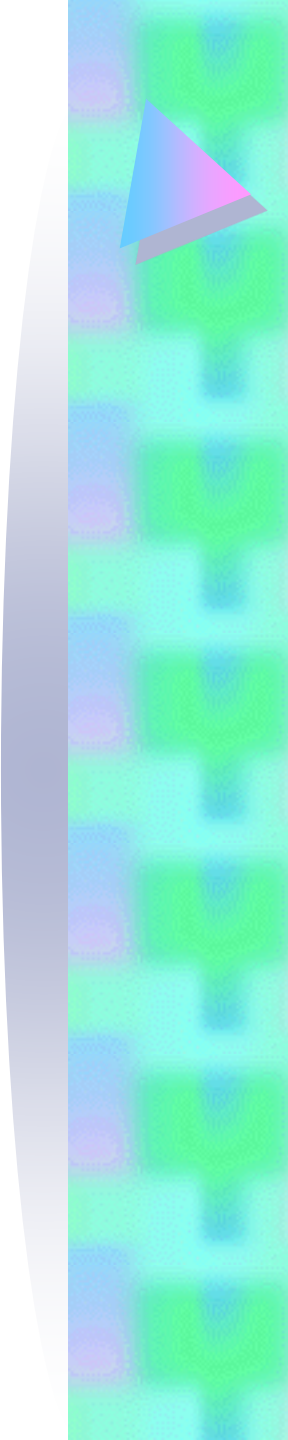




Symptom management in PALLIATIVE CARE

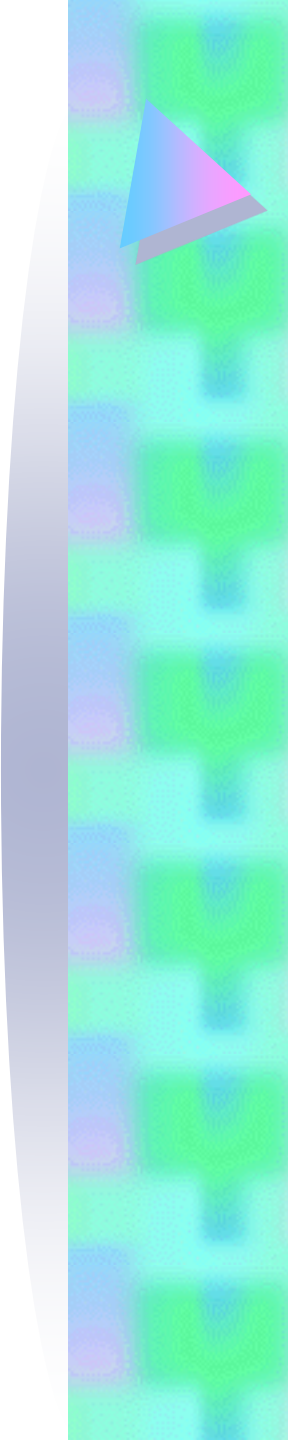
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symptom Management

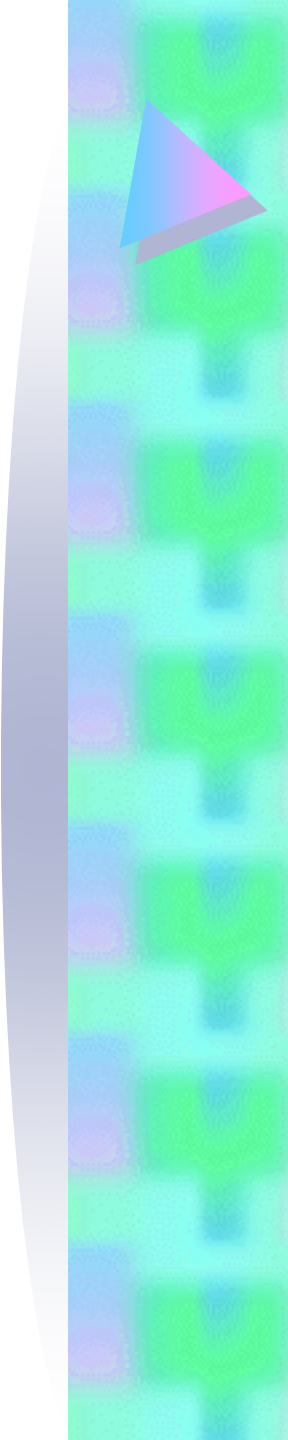
- **Any symptom may be due to :**
 - **Co-existing diseases**
 - **Treatment or drugs**
 - **the disease process**

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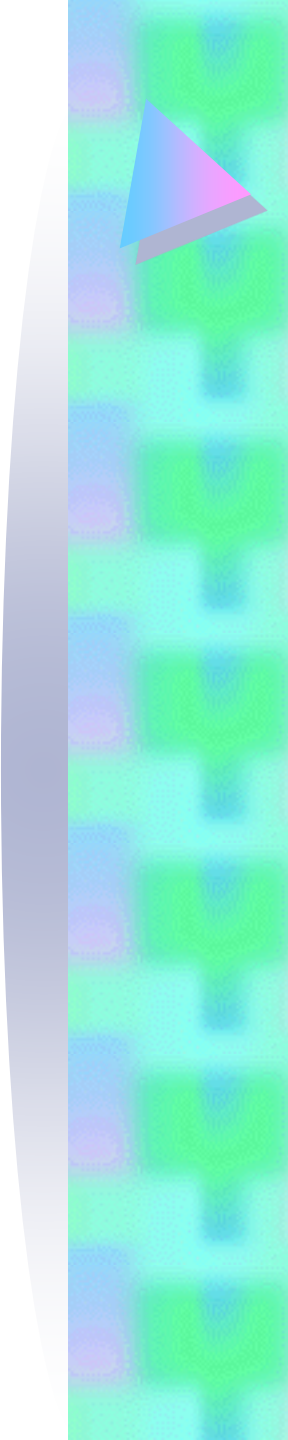
Symptom Management

- ✚ The cause of each symptom should be clearly defined if possible
- ✚ If you don't have a concept (may not be proven) of cause you cannot treat effectively
- ✚ Appropriate investigation may be required
- ✚ Care setting may need to be different



symptom Management

- ✚ **Assess the psychological state of the patient**
- ✚ **This may markedly modify the patient's pain threshold**
- ✚ **Consider the past experience of the symptom for patient and family**

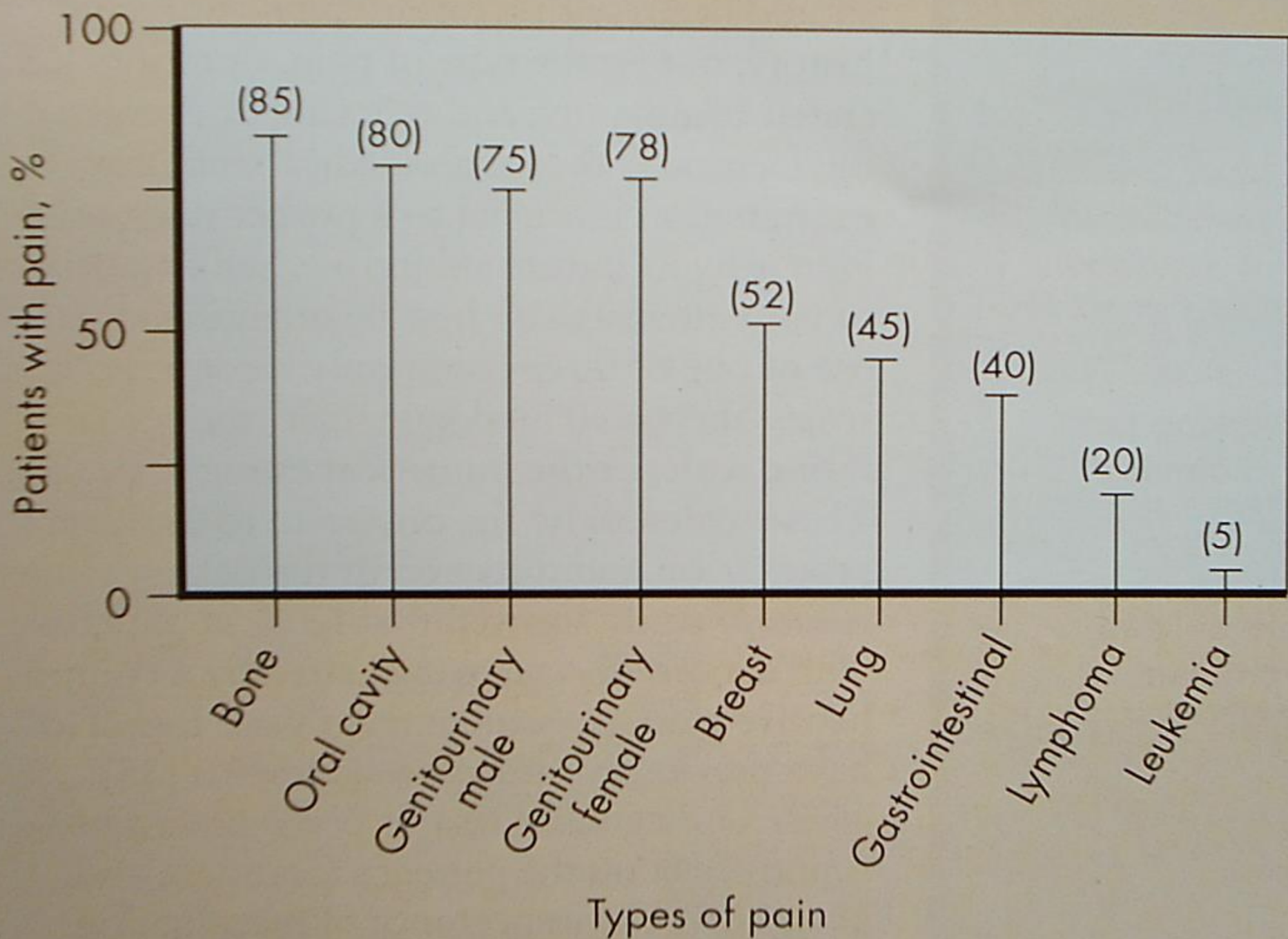


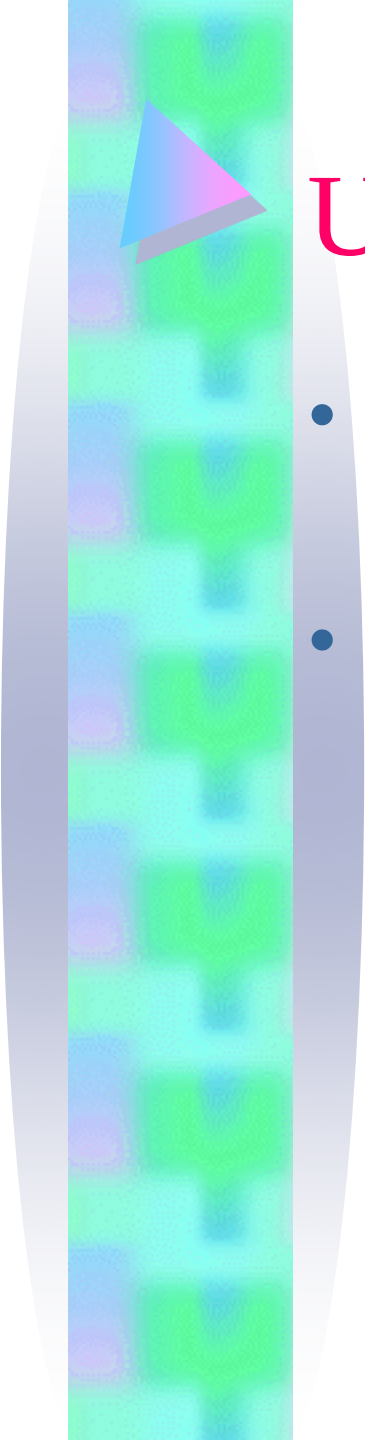
Symptom Management

- **A careful history of each symptom should be taken, noting:**
 - **where it occurs**
 - **it's character**
 - **precipitating factors**
 - **aggravating factors**
 - **relieving factors**

Symptom leading to Palliative ward admission

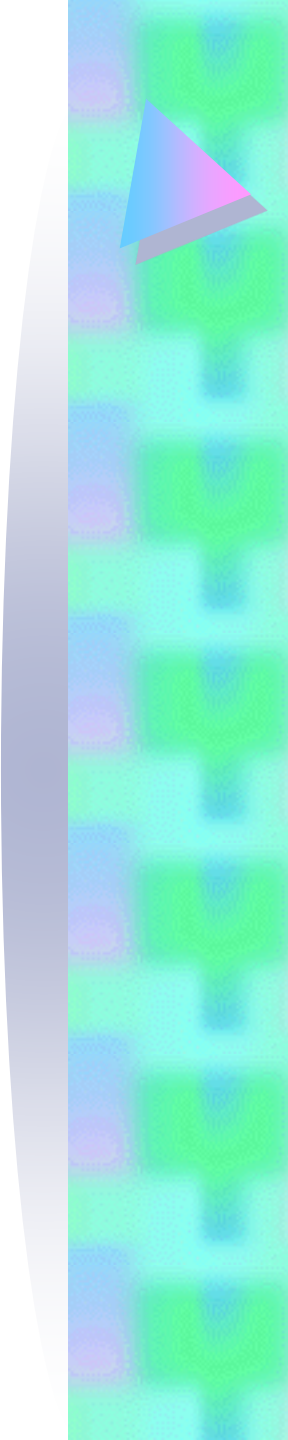
- Pain 55%
- Incontinence 38 %
- Confusion 21%
- Dyspnoea 17%
- Nausea 15%
- Bed sore 12%
- Vomiting 12%
- Open wound 8%
- Cough 7%
- Dysphagia 6%





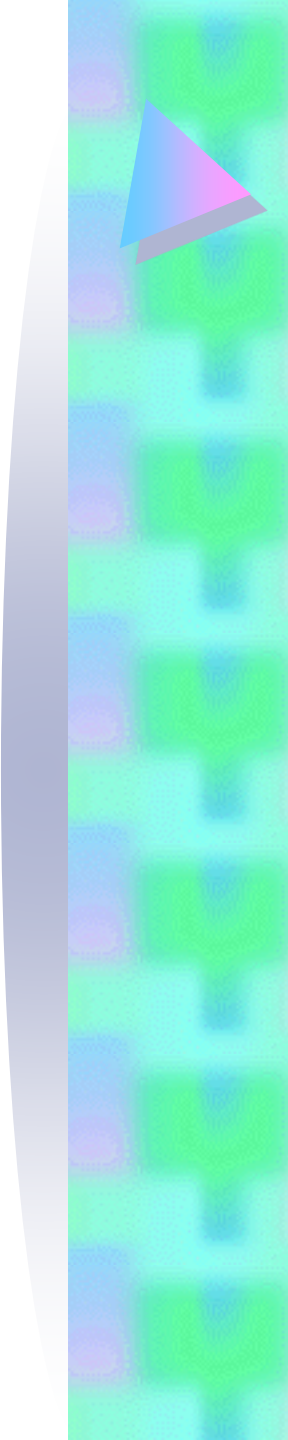
Unique matters

- **A single philosophy does not suit all patients the same way**
- **Need to be flexible**



Be credible

- Believe the patient
- Explore other symptoms
 - patient may volunteer these
 - or you may need to ask directly
- Get the full picture – before responding
- Explore previous interventions
- Measure previous efficacy



Treatment

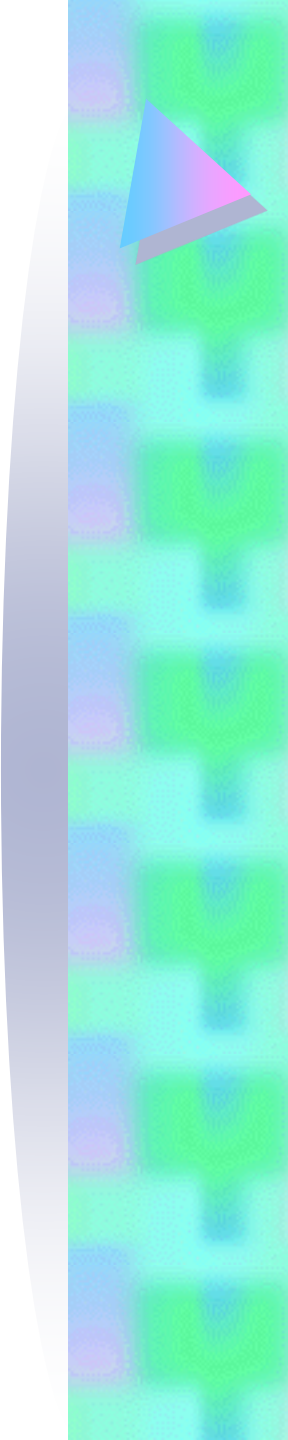
- **Procedural**
- **Chemotherapy**
- **Radiotherapy**
- **Drug therapy**

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Drug treatment

- **Mainstay of medical input**
- **This can give good relief it is remembered to:**
 - **Give the right drug**
 - **In the right dose**
 - **By the right route**
 - **At the right interval**





Route for drug therapy

■ Oral route

- Consider nausea & vomiting

■ Rectal route

- If vomiting occurring
- Cultural preference

■ Sub - Cutaneous route

- via syringe driver

■ Transdermal route

Morphine, mg/d

300
200
100
0

(300)

(100)

(10)

(1)

(1)

PO

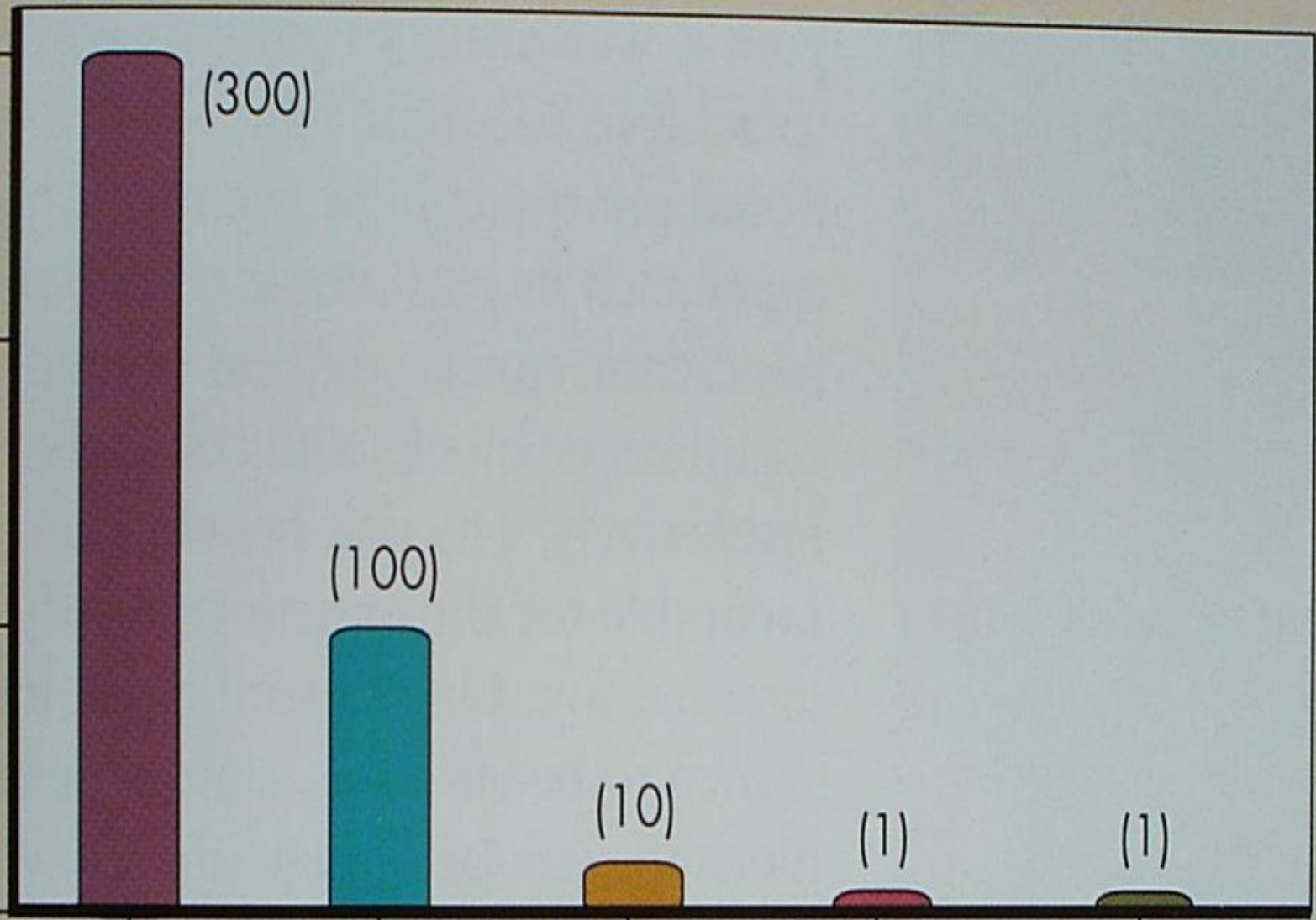
IV/SQ

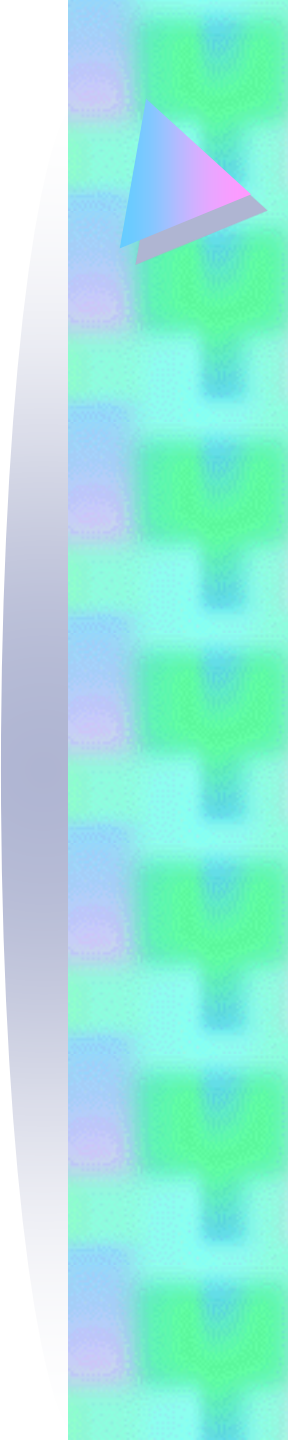
Epidural

Intrathecal

Intraventricular

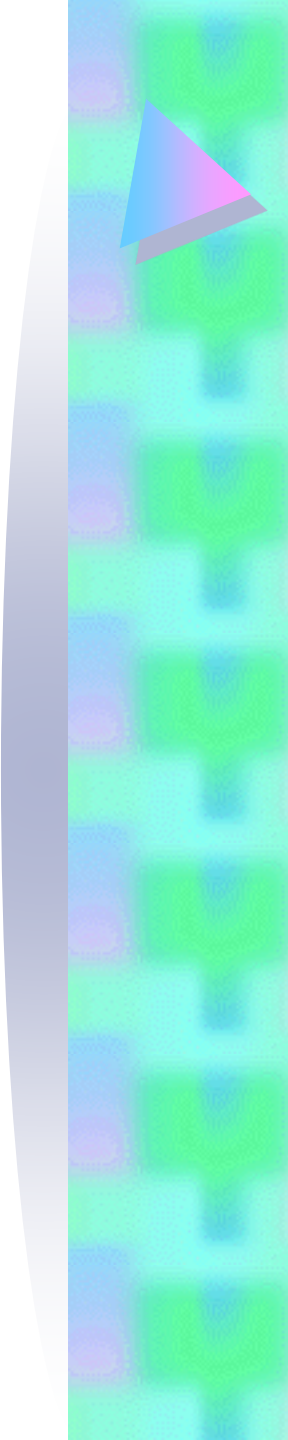
Route of administration





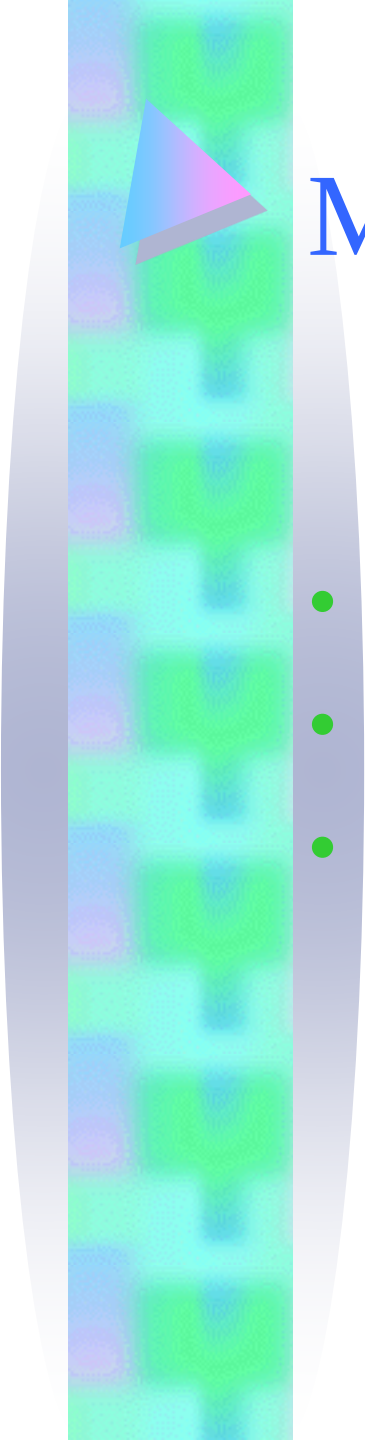
Procedural Treatment

- **Pleural tap**
- **Ascetics tap**
- **Nerve block**
- **Lymph oedema treatment**
- **Fixation of fractures**



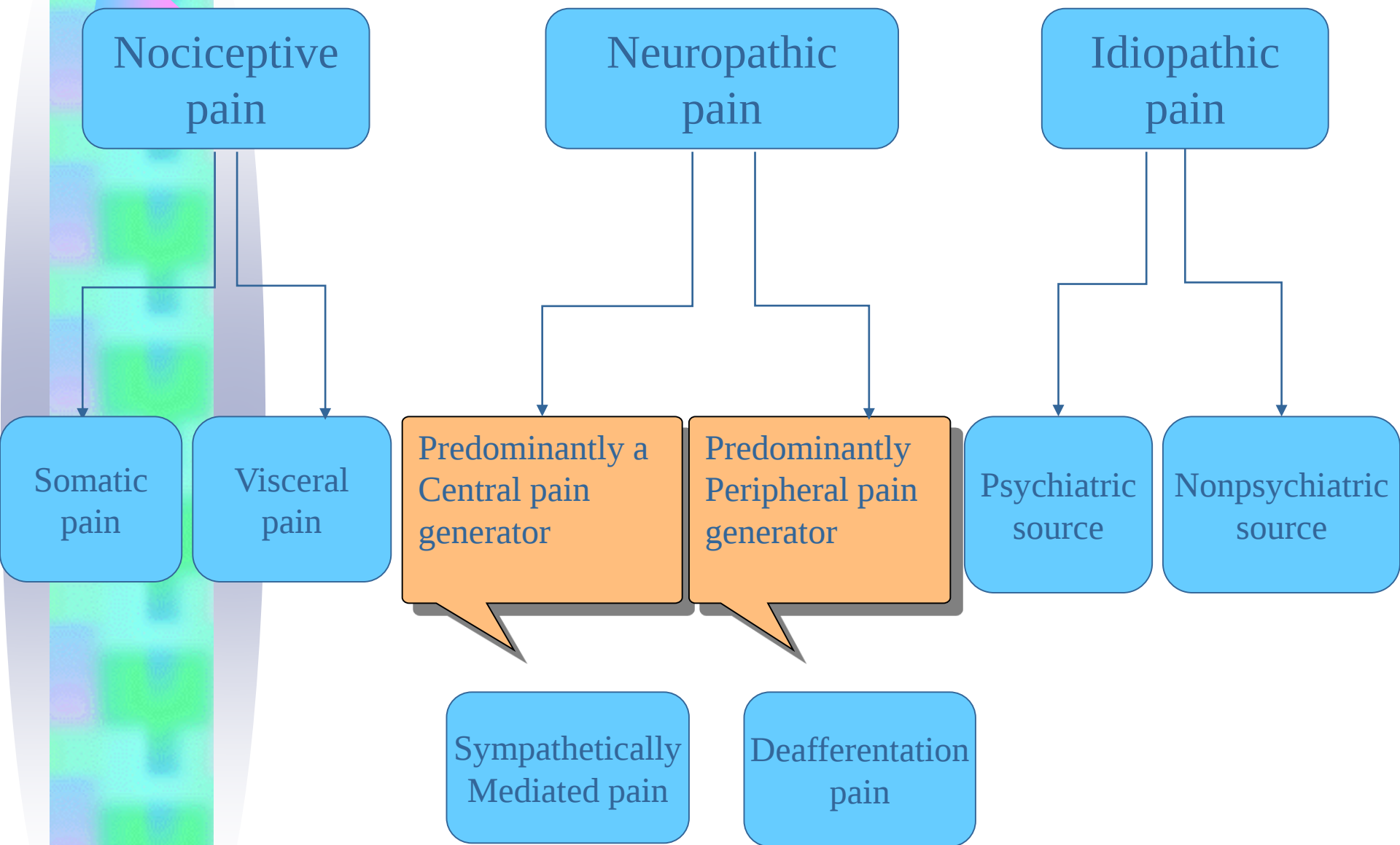
Pain & Cancer

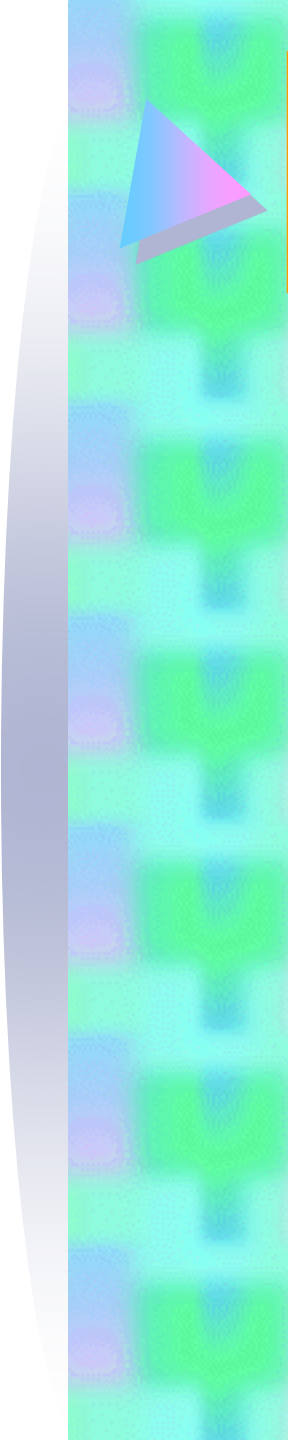
- **Is patient's greatest fear**
- **Are not synonymous**
- **Multiple pain are common**
- **Pain may have different causes**



Multiple pain

- **At least one pain in 20%**
- **Two or more in 80%**
- **One third have four or more pains**

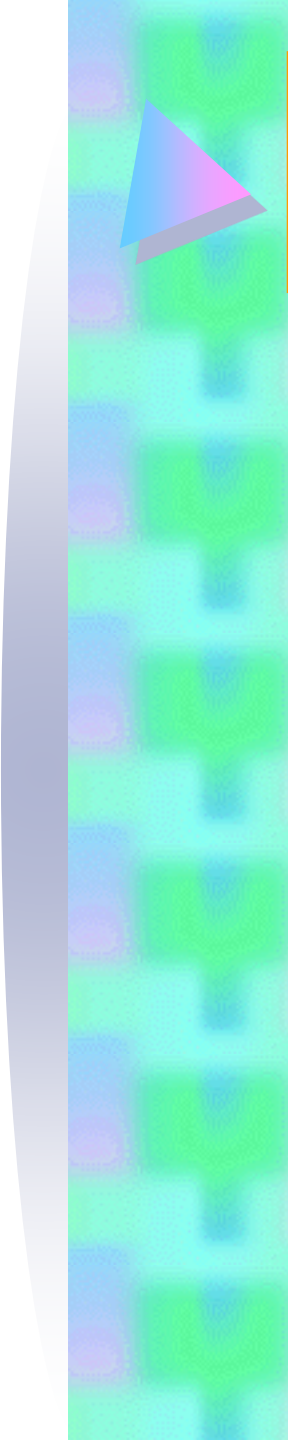




Pain threshold **lowered** by :

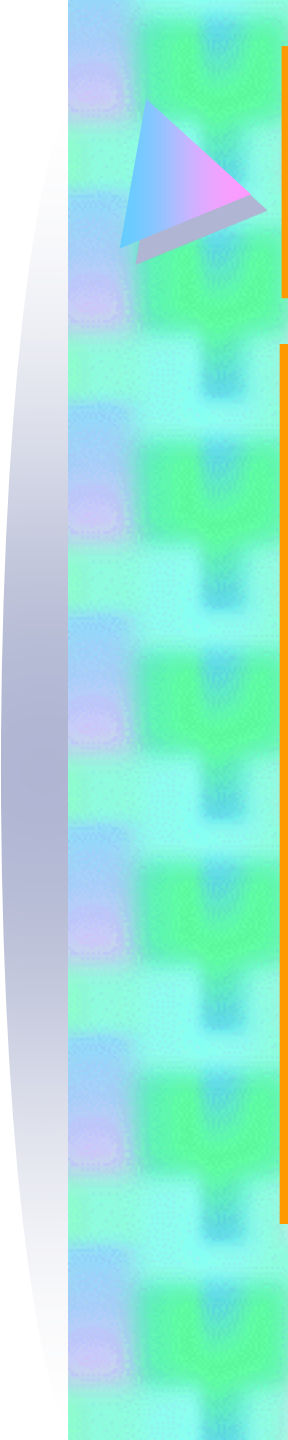
- Discomfort
- Insomnia
- Fatigue
- Anxiety
- Fear
- anger

- Boredom
- Depression
- Mental isolation
- Social abandonment
- sadness



Pain threshold **raised** by

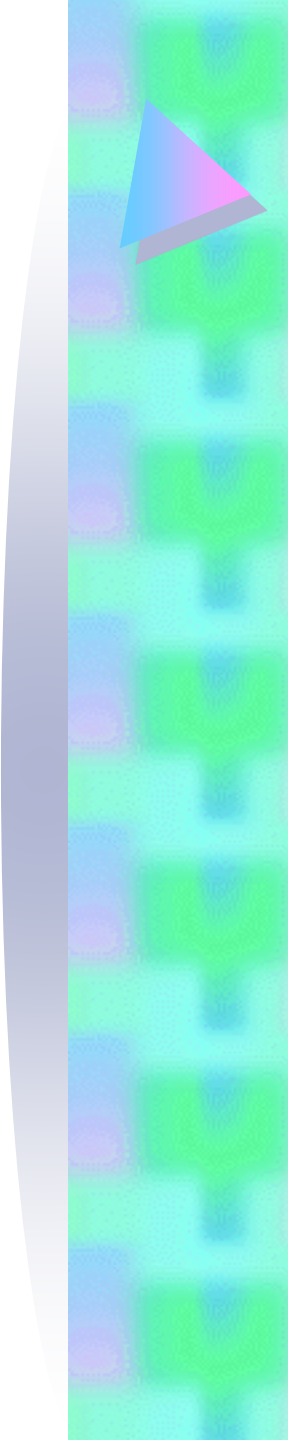
- Relief of other symptoms
- Sleep
- Rest
- Sympathy
- understanding
- Companionship
- Divert ional therapy
- Anxiety therapy
- Mood elevation
- Analgesics
- Anxiolytics
- antidepressant



Pain management points:

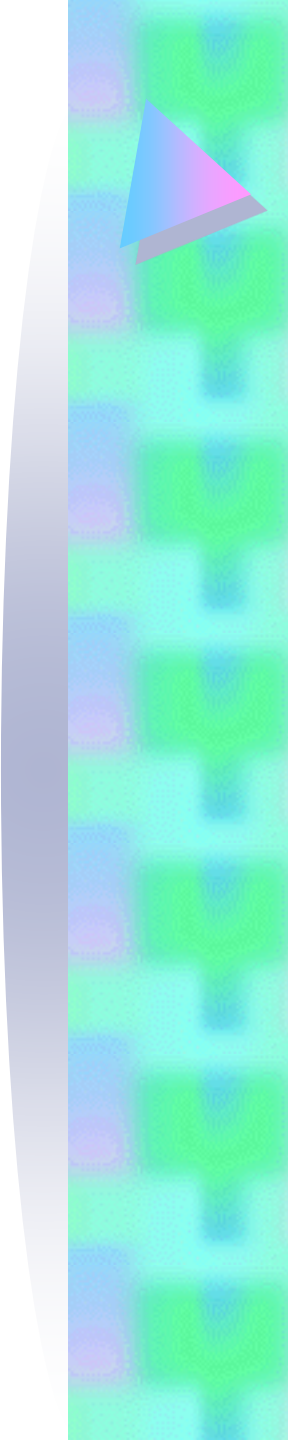
Pain relief may be achieved by:

- Examination & Explanation**
- Modification of pathology**
- Elevation of pain threshold**
- Interruption of pain pathways**
- Life style:modification /
immobilisation**



Top 10 pains

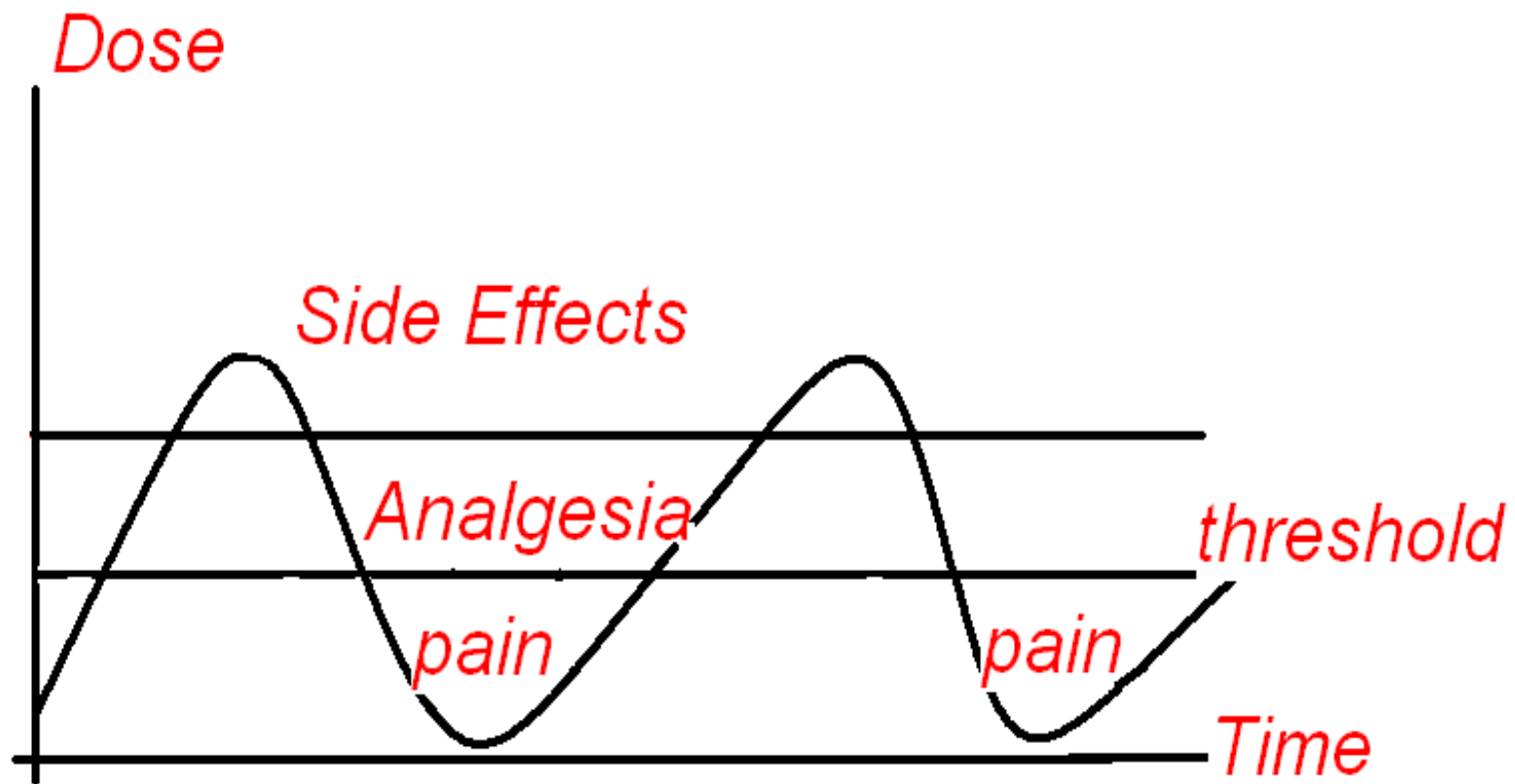
- **Bone**
- **Nerve compression**
- **Soft tissue**
- **Visceral**
- **myofacial**
- **Constipation**
- **Muscle spasm**
- **Back pain**
- **Chronic post operative**
- **Capsulitis**



Emotional pain

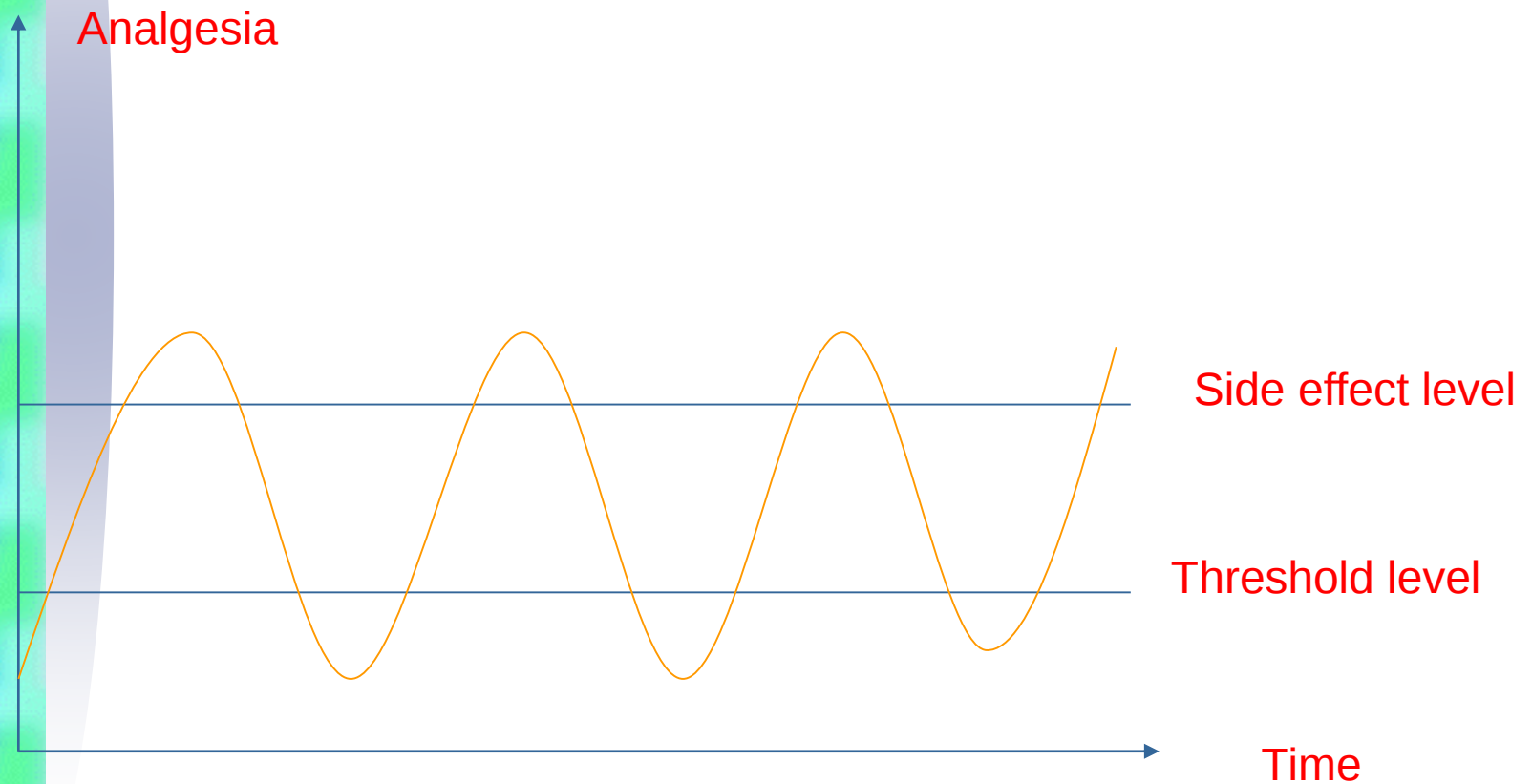
- **To be considered if expected progress not made**
- **If the picture of the pain or the picture of the response to treatment doesn't make sense**

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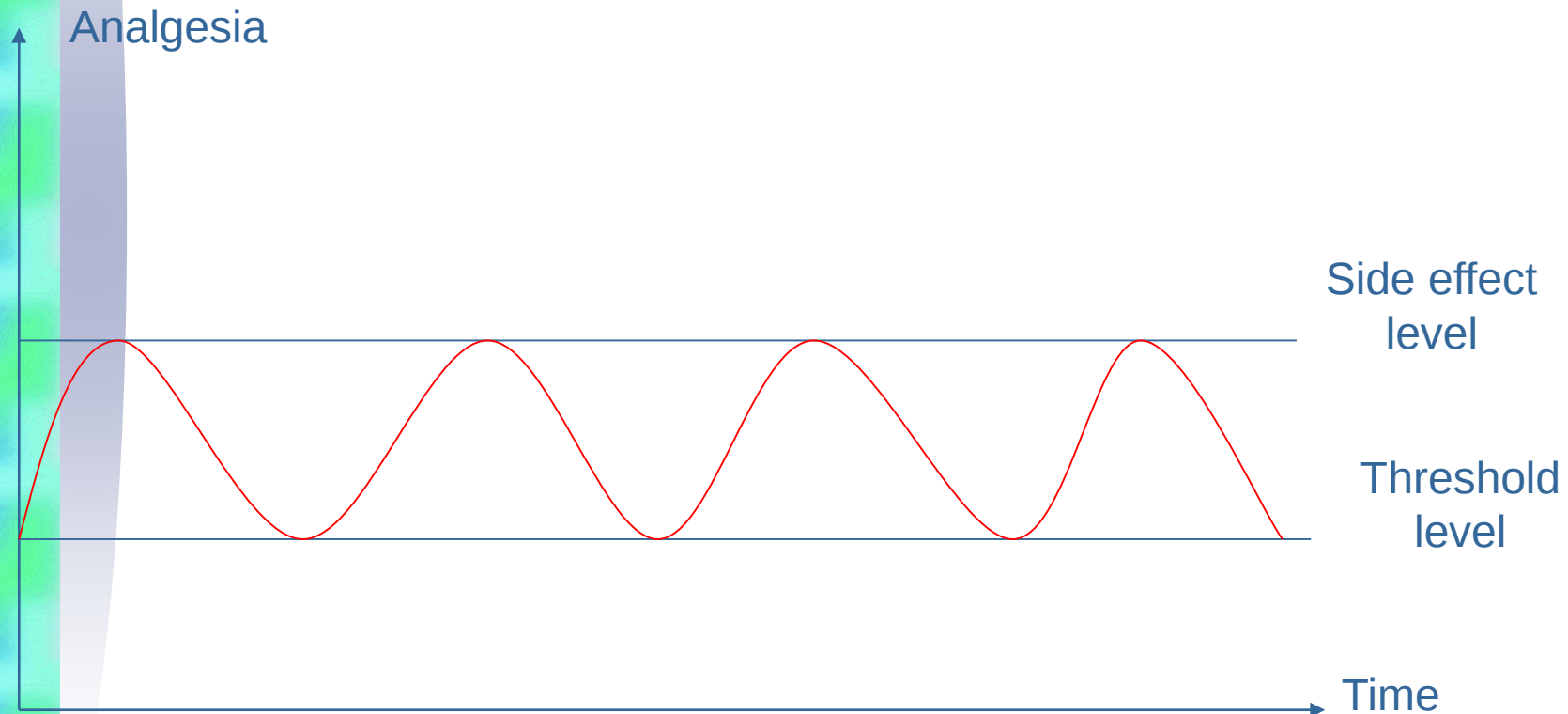
Pattern of pain

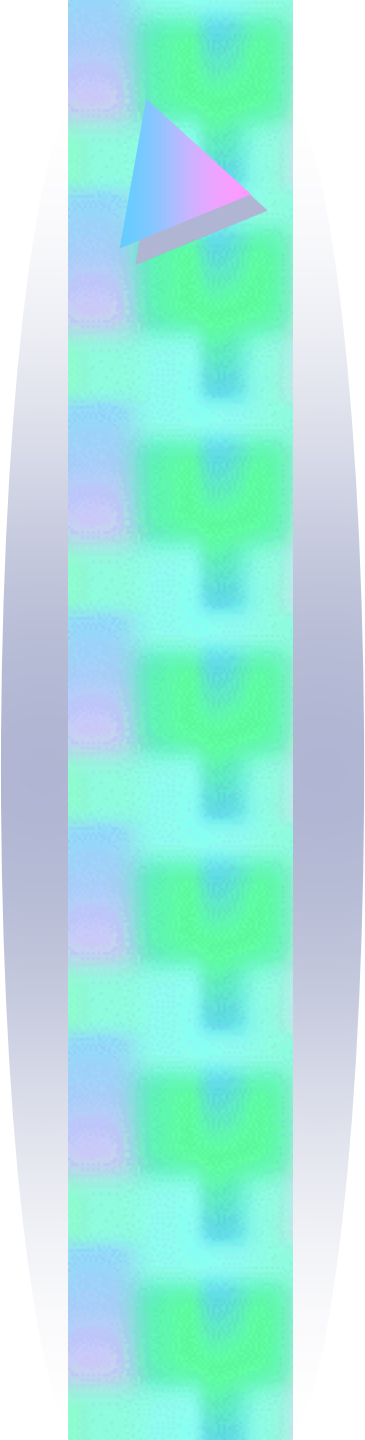
- 4 hourly drug given 6 hourly



Pattern of pain

- **Comparing 4 hourly drug given 4 hourly**

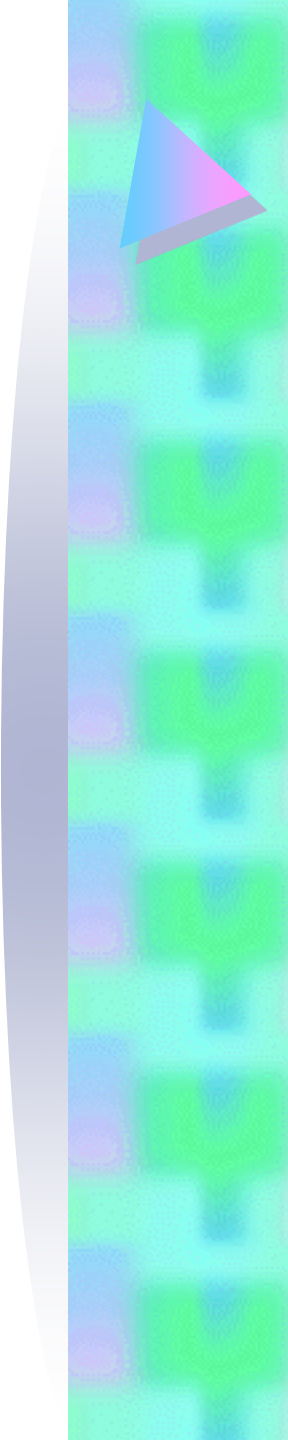




Keep in mind

NO PRN

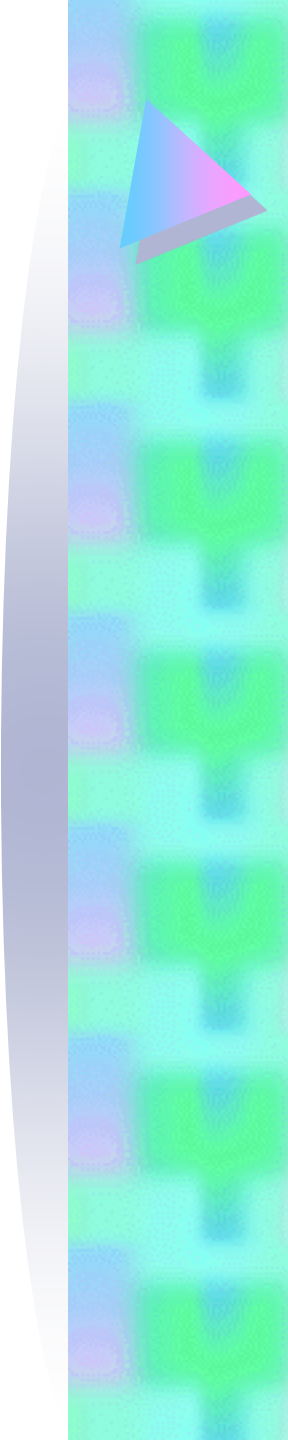
- **Is Pro Re Nata**
- **Is Pain Relief Negligible**



Pharmacology of pain

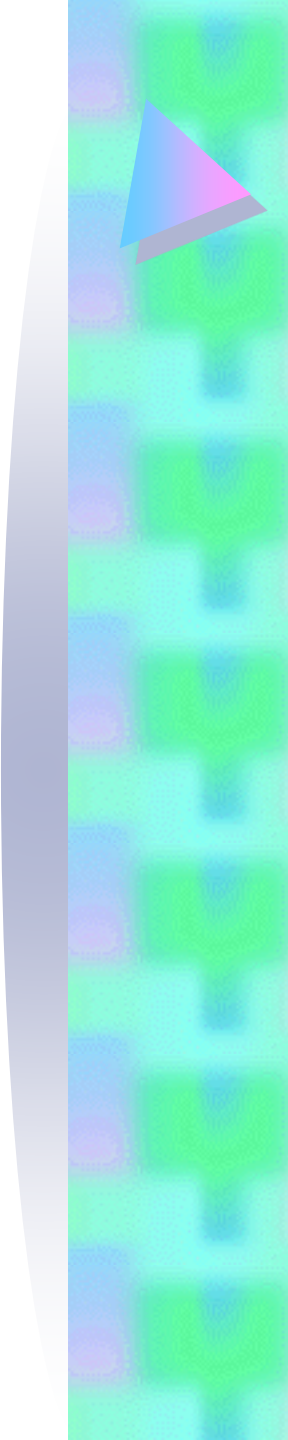
- **Opiate responsive**
- **Semi-responsive**
- **Opiate resistant**
- **Consider opiate rotation**
- **Newer opiate**
- **Older opiate - methadon**

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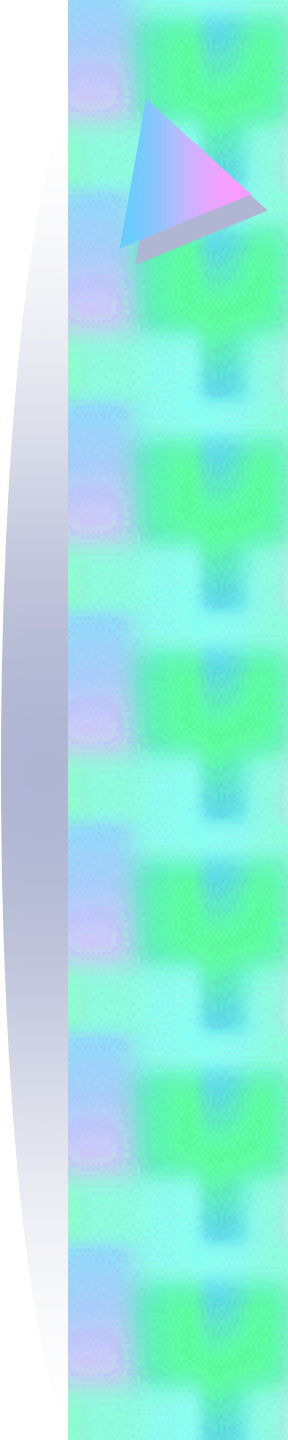
Common mistakes

- **Cancer & other causes**
- **Non drug treatment of spasm**
- **Each pain needs it own programme**
- **Some pain are not opiate sensitive**
- **Laissez-faire approach to timetable**
- **And to patient and cancer education**



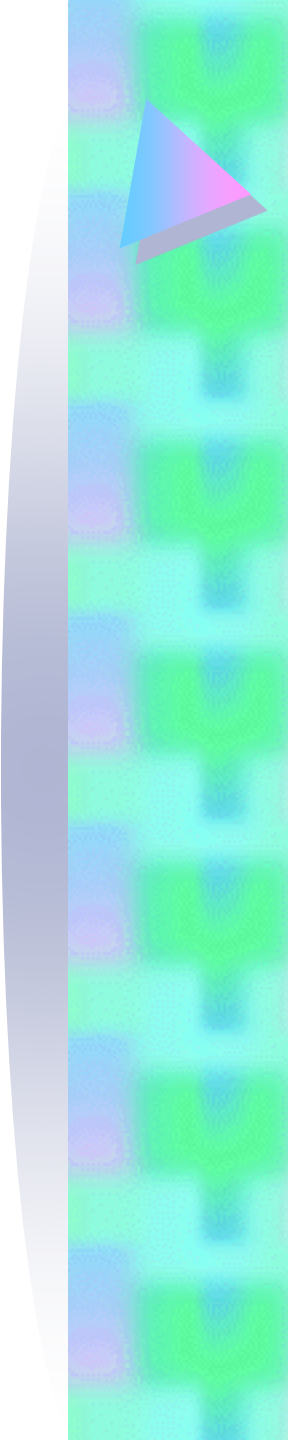
Common mistakes

- **Move to less than equipotent dose**
- **Decrease interval rather than raise dose**
- **Use injection when oral possible**
 - **Consider equipotency**
 - **Consider patterns of behaviour**
- **Failure**
 - **To monitor & treat side effects**
 - **To deal with psychological issues**
 - **To listen to the patient**



Cancer Symptoms

• Asthenia	90%
• Anorexia	80%
• Pain	76%
• Nausea	68%
• Constipation	65%
• Sedation/confusion	60%
• Dyspnea	12%



دردهای سرطانی

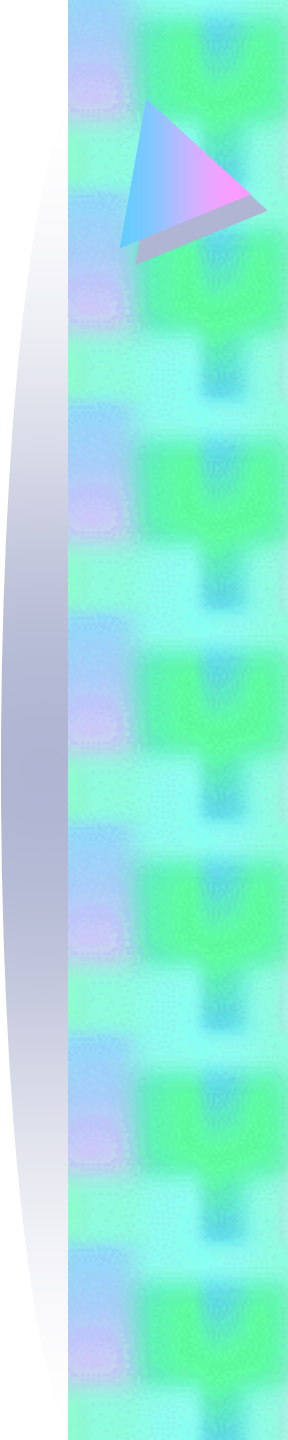
یک مشکل طب جهانی است

سالانه شش میلیون نفر مبتلا شده چهار میلیون نفر زندگی
شان را از دست میدهند

در ۷۰٪ بیماران در مراحل پیشرفته درد ظاهر میشود

این نسبت در مرحله تر مینال به ۹۰٪ میرسد

هر روز قریب ۸ میلیون نفر از درد ناشی از کانسر رنج
میبرند



سندرمهای درد در بیماران کانسری

الف) ۷۷٪ در پی تهاجم تومور و فشار آن به بافت‌های حساس درد ایجاد میکنند

ب) ۱۹٪ در اثنای درمان مثل: شیمی درمانی / رادیوتراپی و جراحی درد پیدا میکنند

ج) ۴٪ درد به عوامل غیر کانسری مربوط میشود

دردمندان کانسری را سه گروه بررسی میکنیم

بیماران با درد حاد:

با تشخیص و درمان میتواند در ارتباط باشد. علت براحتی شناخته میشود. با ظهور درد توانایی تحمل آن تحت تاثیر قرار میگیرد

بیماران با درد مزمن:

۱) با پیشرفت بیماری در ارتباط است. با تهاجم تومور شدت درد زیاد میشود. فاکتورهای سایکولوژیک به تابلوی اولیه اضافه میشود. با مشاهده عدم درمان علت... پرداختن به درمان درد بهترین راه انتخابی است.

۲) ناشی از درمان باشد {سندرم درد ناشی از انسیزیون جراحی بهبود نیافته. سندرمهای نوروپاتیک بدنبال جراحی و رادیو تراپی و یاشیمی درمانی}

بیماران با درد در حال مرگ:

اول از همه بایستی راحتی بیمار را فراهم کرد

Cancer pain management: Multidisciplinary approach

➤ **Primary anticancer treatment**

Oncologist
Radiation oncologist
Immunologist
Surgeon

➤ **Pain management: pharmacological/procedural/psychiatric/behavioral**

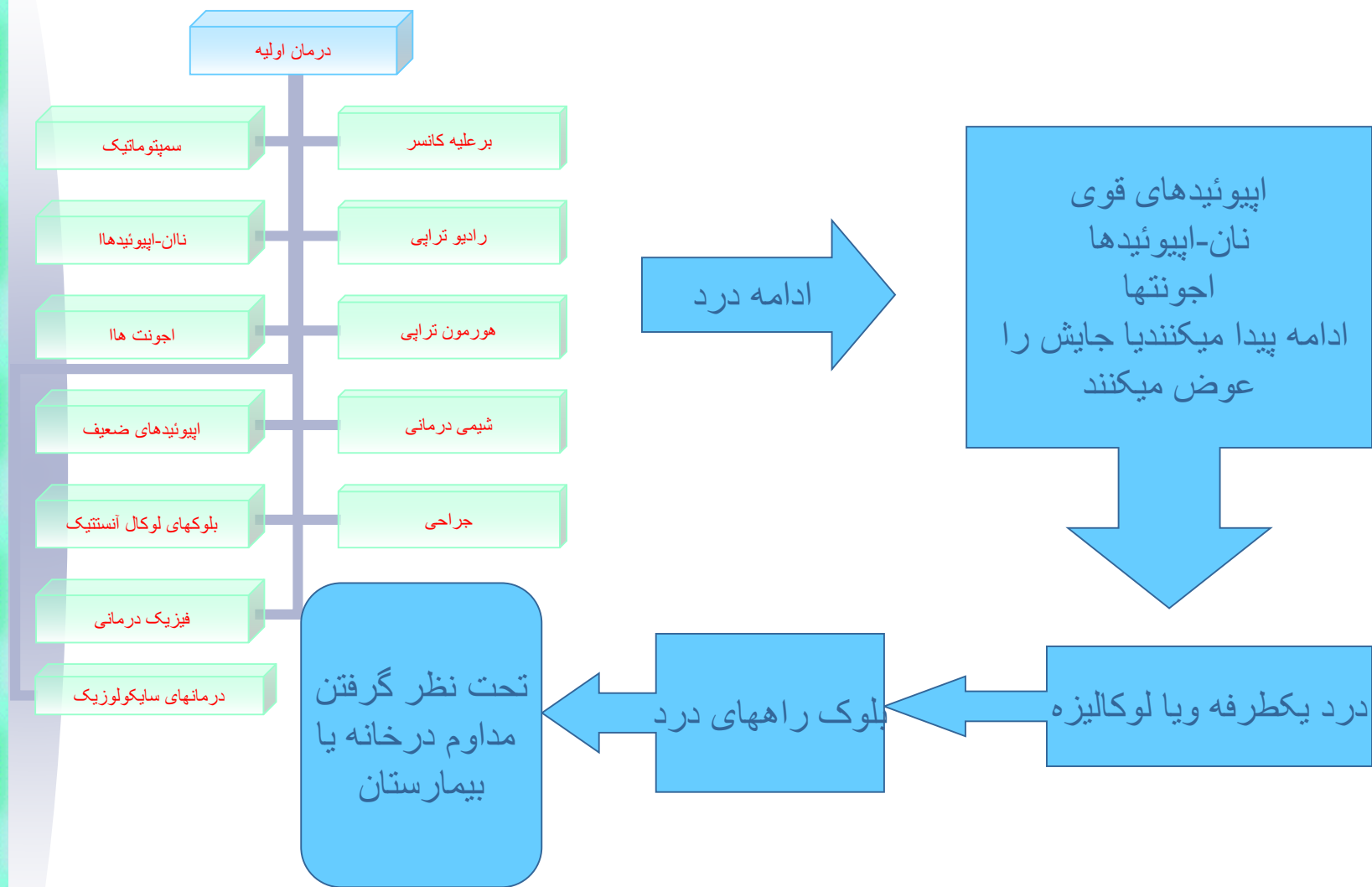
Anesthesiologist
Neurologist
Internist
Psychiatrist
Behavioral therapist
Physiatrist

➤ **Neuroinvasive therapy**

Neurosurgeon
Anesthesiologist

➤ **General care**

Internist
Social worker
Family
Spiritual counselor
Psychiatrist
Physiatrist



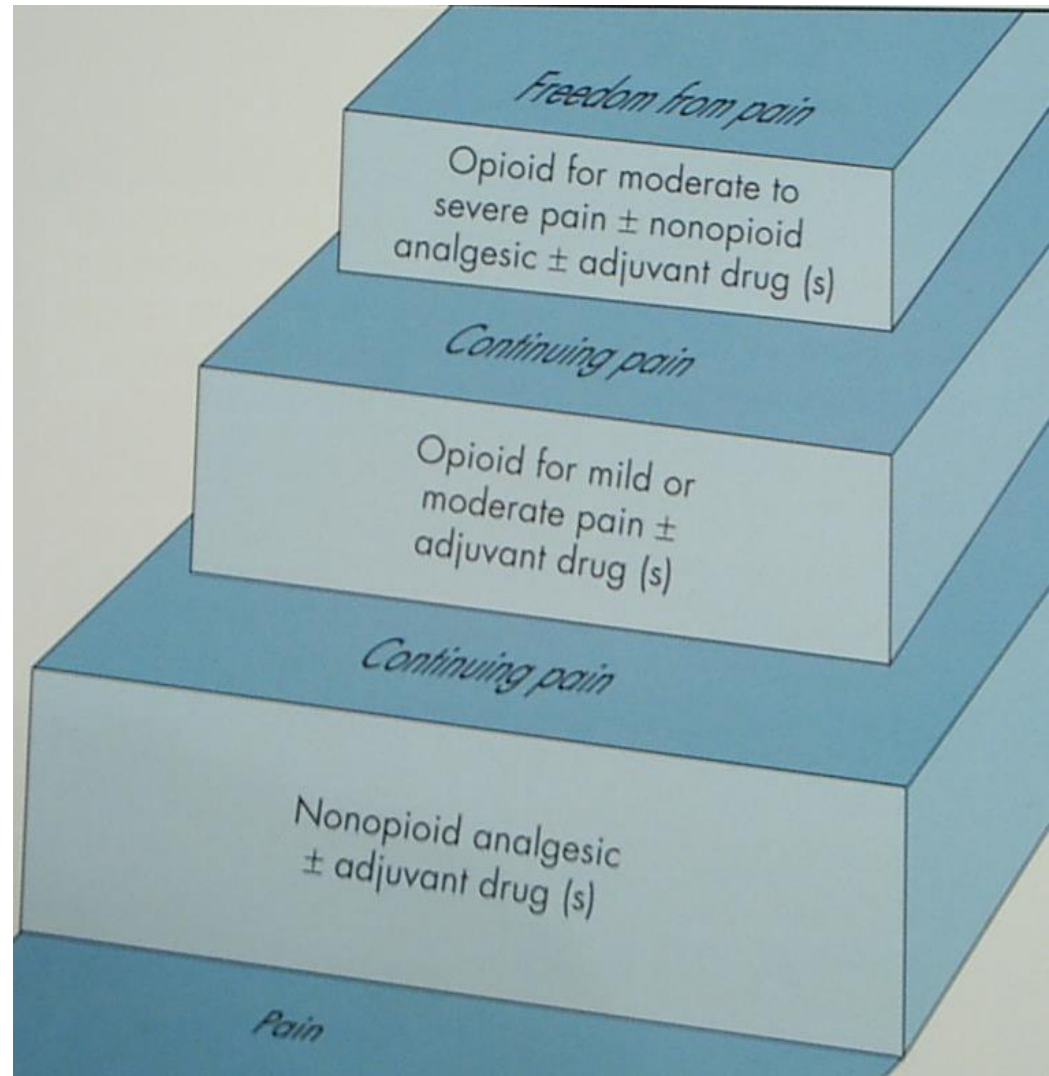
استراتژی درمان

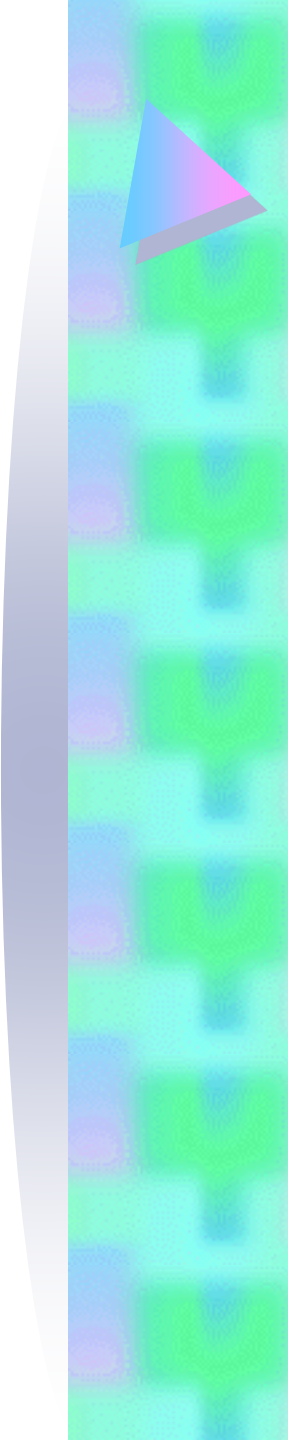
اهداف:

مدت زمان خواب
بیدرد را زیاد
کند.

عدم احساس درد
در حال
استراحت.

عدم احساس درد
در زمان
ایستادن
و حرکت.

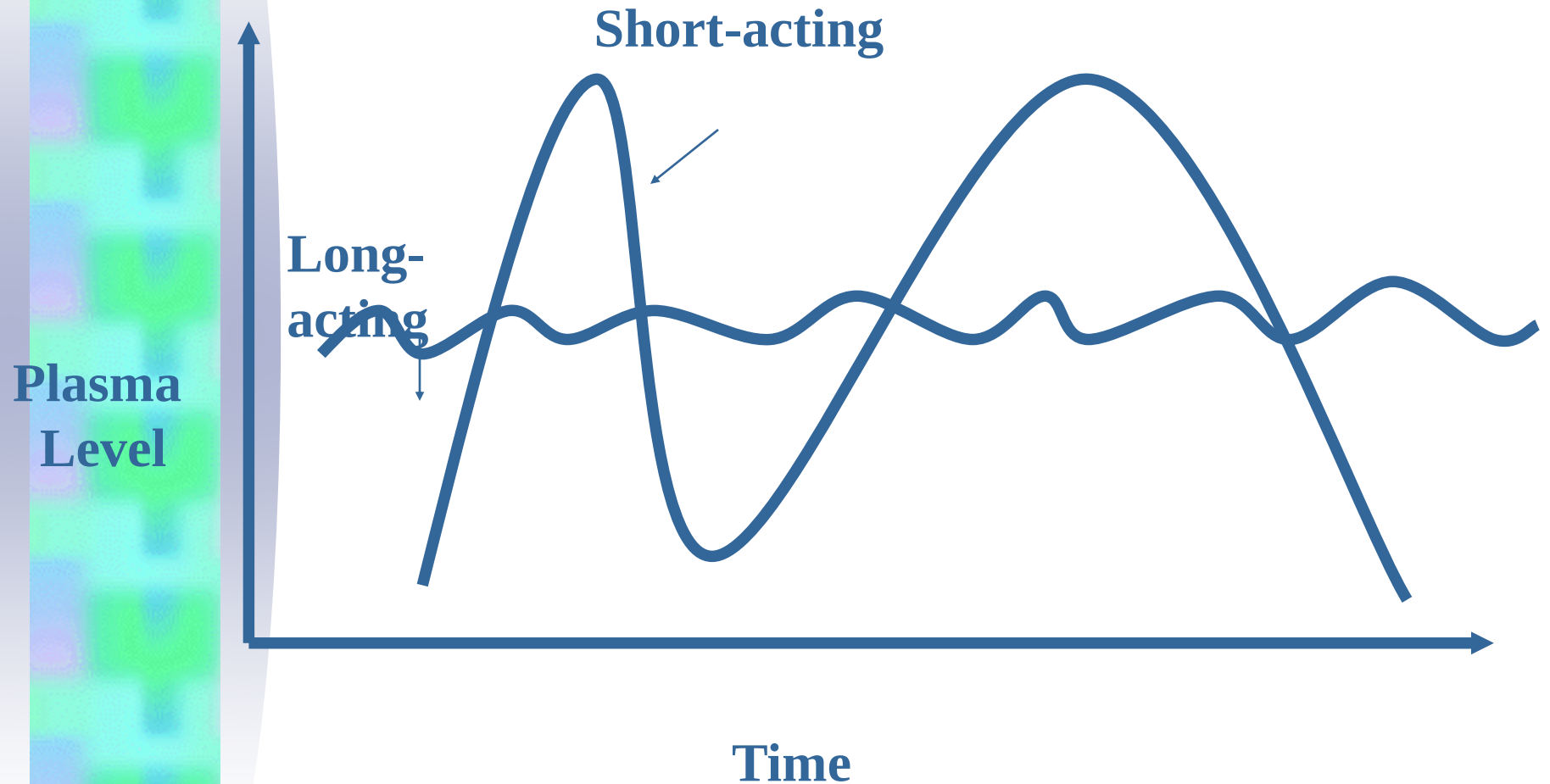


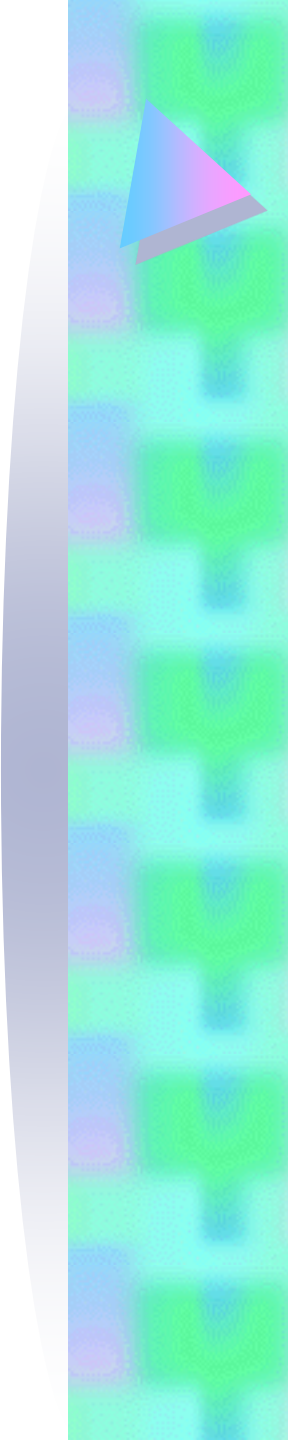


Recommendations

- **Long-acting,
not short-acting**
- **Dose by the clock,
not PRN**
- **Use adjuvants**

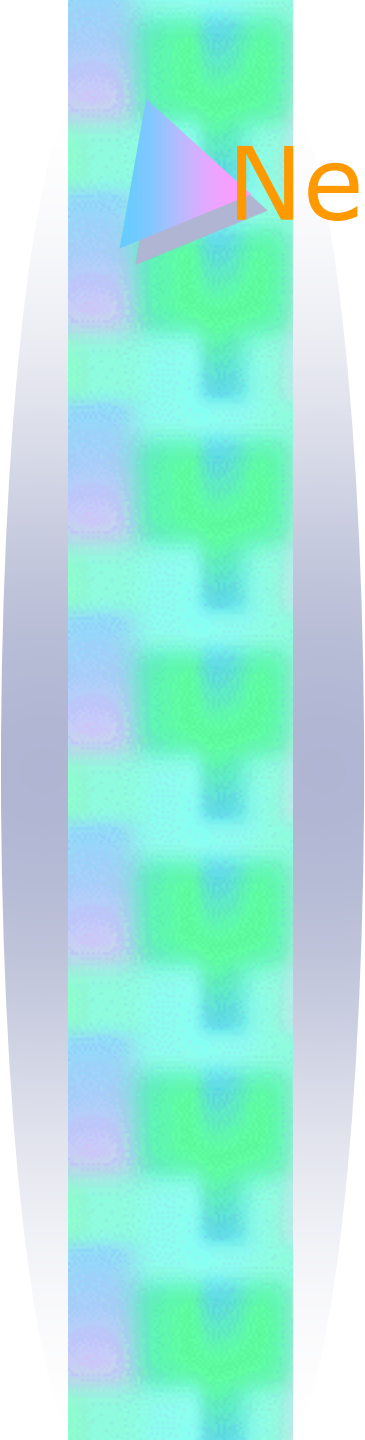
Opioids





Psychosocial Effects of Chronic Pain

- **Loss of employment / income**
- **Depression, fear, anxiety**
- **Isolation**
- **Sleep disorders**
- **Marital and family dysfunction**



Nerve Cutting Procedures

- ☐ Uterosacral transection
- ☐ Presacral neurectomy
- ☐ Uterovaginal ganglion excision
- ☐ Ovarian sympathectomy

THERAPEUTIC PAIN INTERVENTION OPTION

☀ Non pharmacologic

☀ Neurolytic block

☀ peripheral nerve blocks

☀ Autonomic blocks

☀ Spinal injection

☀ Cryoablation/RF lesioning

☀ Nonneurolytic block

☀ Trigger point injection

☀ Perineural steroid injection

☀ Sympathetic block

☀ Pituitary ablation

☀ Cordotomy (percutaneous ,open)

☀ Thalatomy

☀ Electrical Stimulation of inhibitory centers

☀ Biofeedback and relaxation techniques

☀ Physiatics

☀ Psychiatric therapy

☀ Pharmacologic

☀ Opioids(intraspinal,PCA , oral,IV)

☀ Tricyclic antidepressants

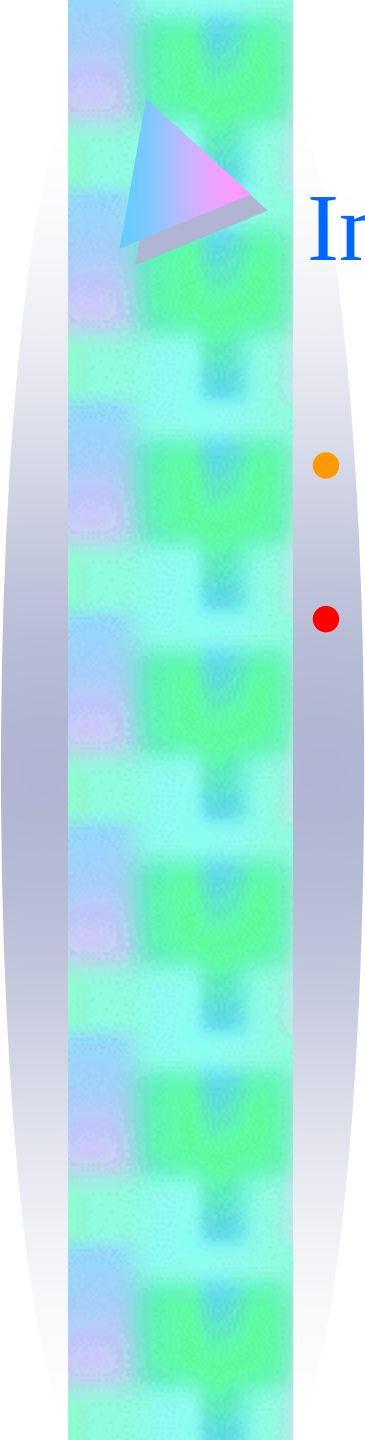
☀ NSAIDs

☀ Steroids

☀ B-Blockers

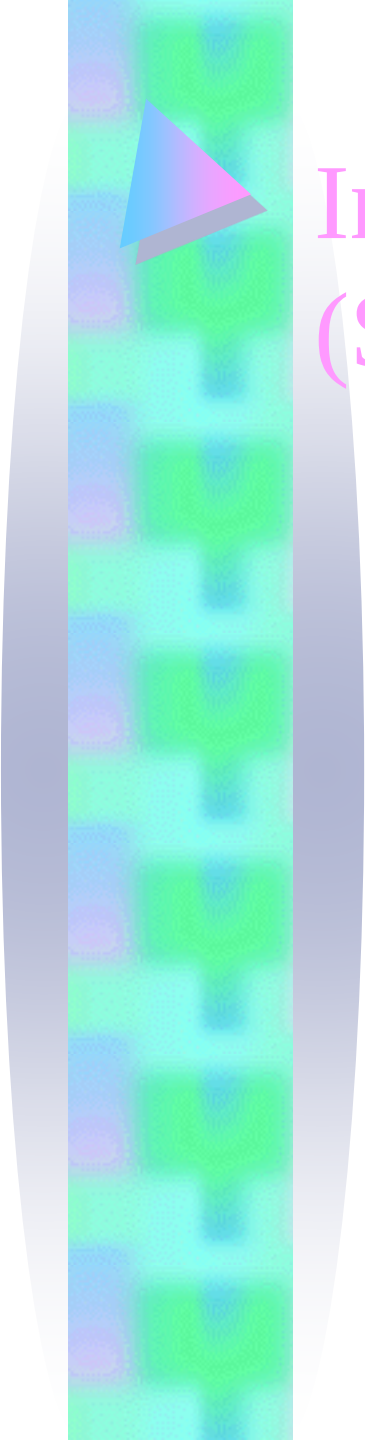
☀ Antiemetics

☀ Antispasmodic



Implantable Technology for Pain Control

- **Spinal Cord Stimulation**
- **Subarachnoid Narcotic**



Indication for Intra Spinal Opioids (SAN)

Diffuse cancer pain

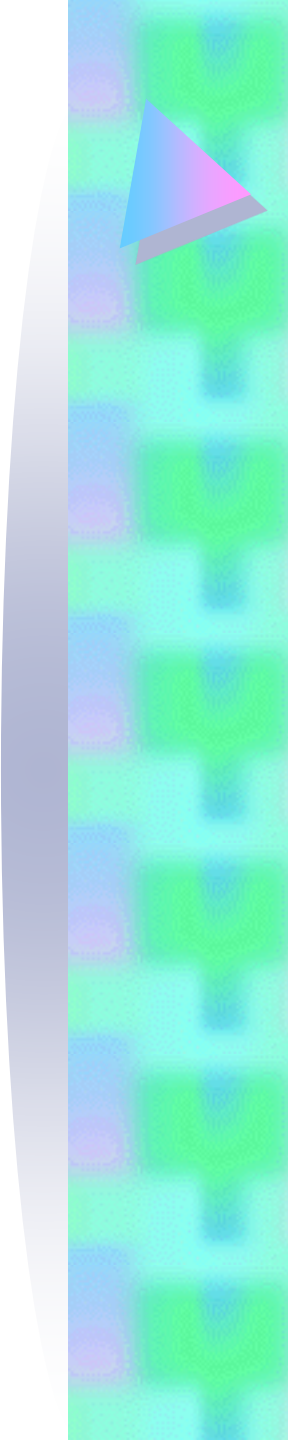
Osteoporosis

Visceral pain

Axial somatic pain

Head & Neck pain

Multiple sclerosis



Indication for S.C.S

- Lumbar radiculopathy
- cervical radiculopathy
- Mononeuropathy
- Intercostal neuralgia
- Peripheral vascular disease

Indication for both of SAN & SCS

Rflex sympathetic dystrophy

Causalgia

Fail back surgery Syndrome

Arachnoiditis

Diabetic neuropathy

Alcoholic neuropathy

AIDS- related neuropathy

Stump pain

Phantom limb pain

PHN

Spinal cord injury

Plexus neuropathy

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Palliative Ward- Imam Reza Hospital

