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**

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

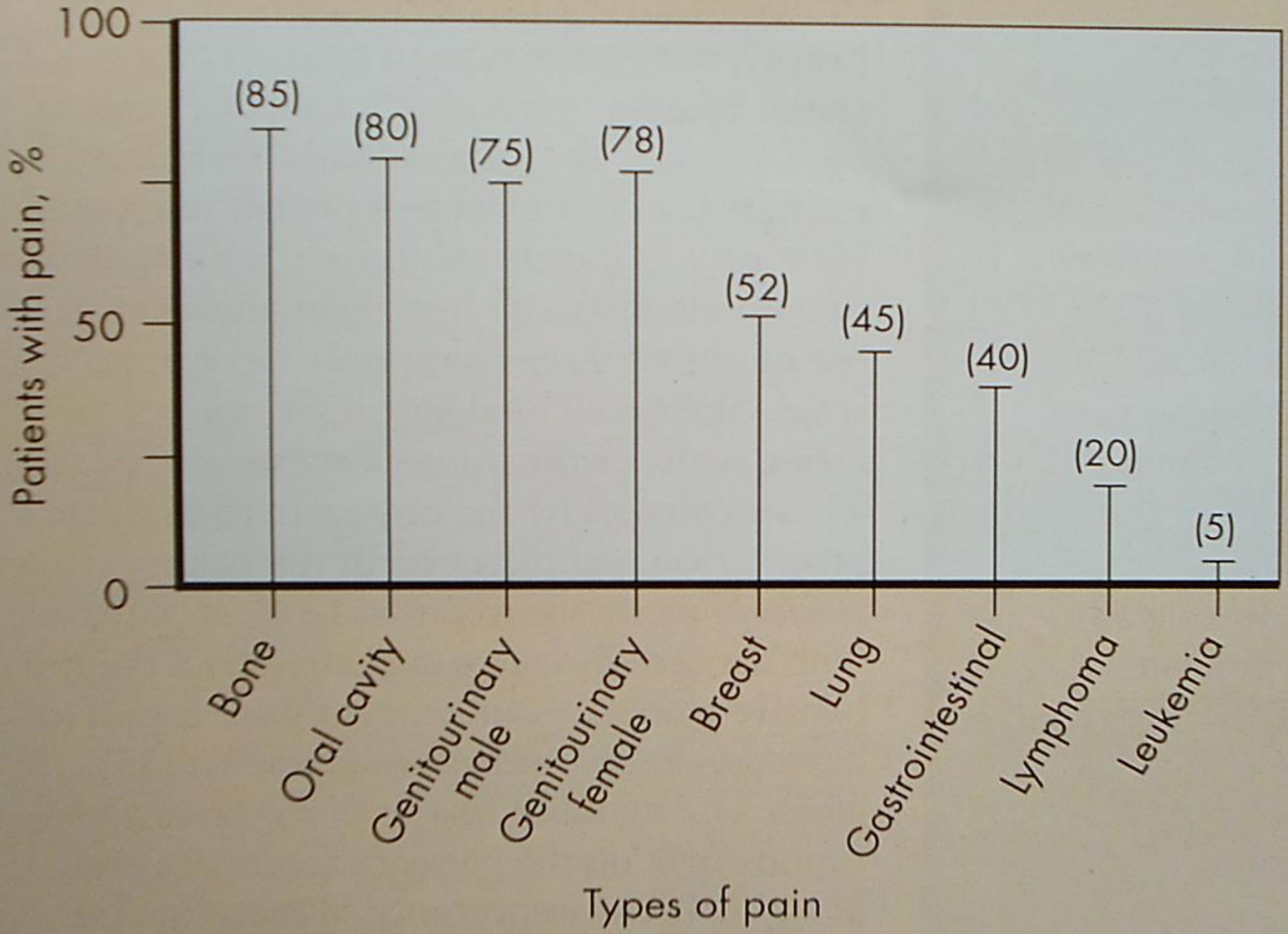
- **Assess the psychological state of the patient**
- **This may markedly modify the patient's pain threshold**
- **Consider the past experience of the symptom for patient and family**

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%
- Bedsore 12%
- Vomiting 12%
- Open wound 8%
- Cough 7%
- Dysphagia 6%


100
50
0
Patients with pain, %
(85)
(80)
(75)
(78)
(52)
(45)
(40)
(20)
(5)
Bone
Oral cavity
Genitourinary male
Genitourinary female
Breast
Lung
Gastrointestinal
Lymphoma
Leukemia
Types of pain

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

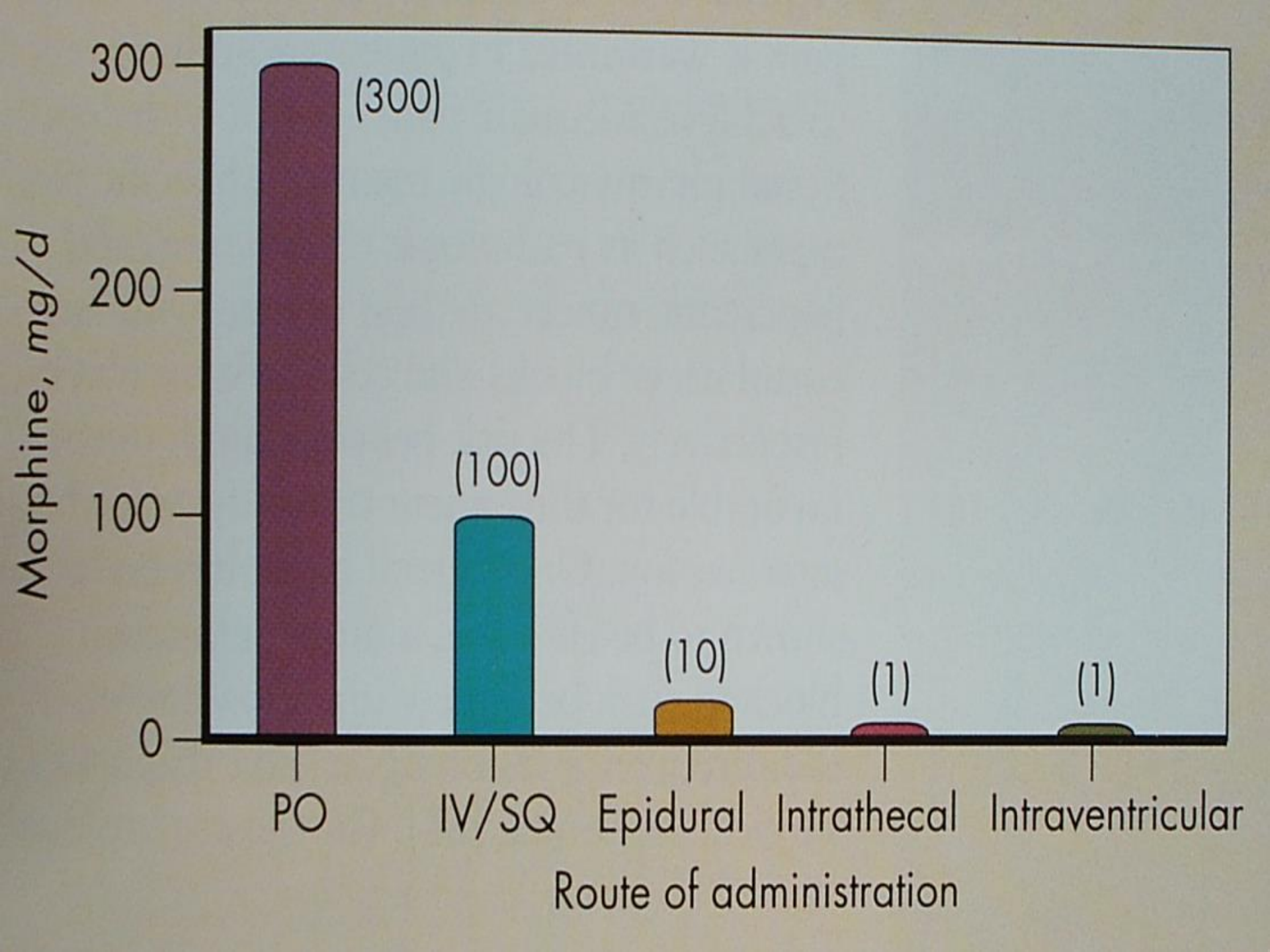
- **Procedural**
- **Chemotherapy**
- **Radiotherapy**
- **Drug therapy**

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**


300
200
100
0
Morphine, mg/d
(300)
(100)
(10)
(1)
(1)
PO
IV/SQ
Epidural
Intrathecal
Intraventricular
Route of administration

Procedural Treatment

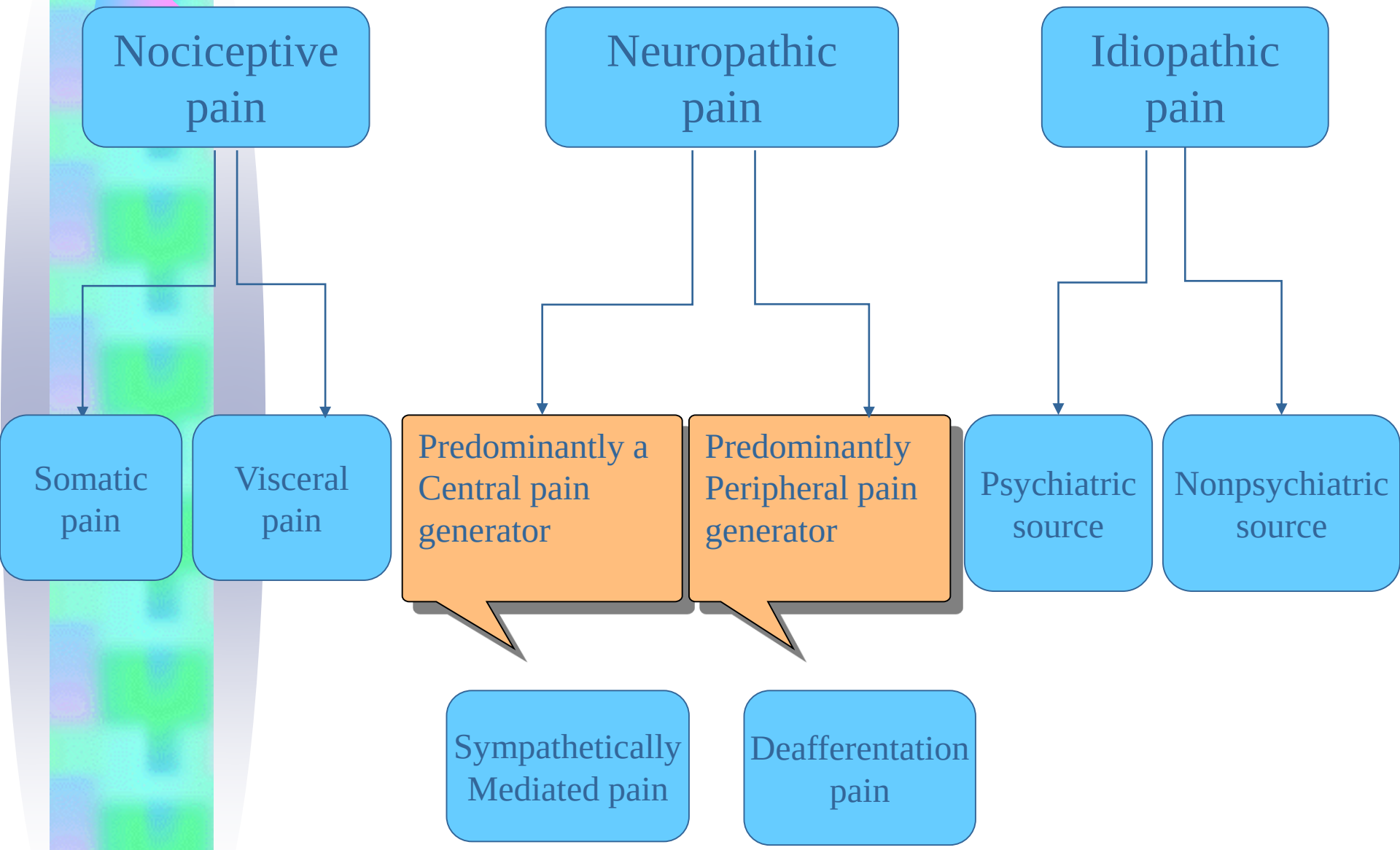
- **Pleural tap**
- **Ascetics tap**
- **Nerve block**
- **Lymph oedema treatment**
- **Fixation of fractures**

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**


Nociceptive pain
Neuropathic pain
Idiopathic pain
Somatic pain
Visceral pain
Predominantly a Central pain generator
Predominantly Peripheral pain generator
Psychiatric source
Nonpsychiatric source
Sympathetically Mediated pain
Deafferentation pain

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:

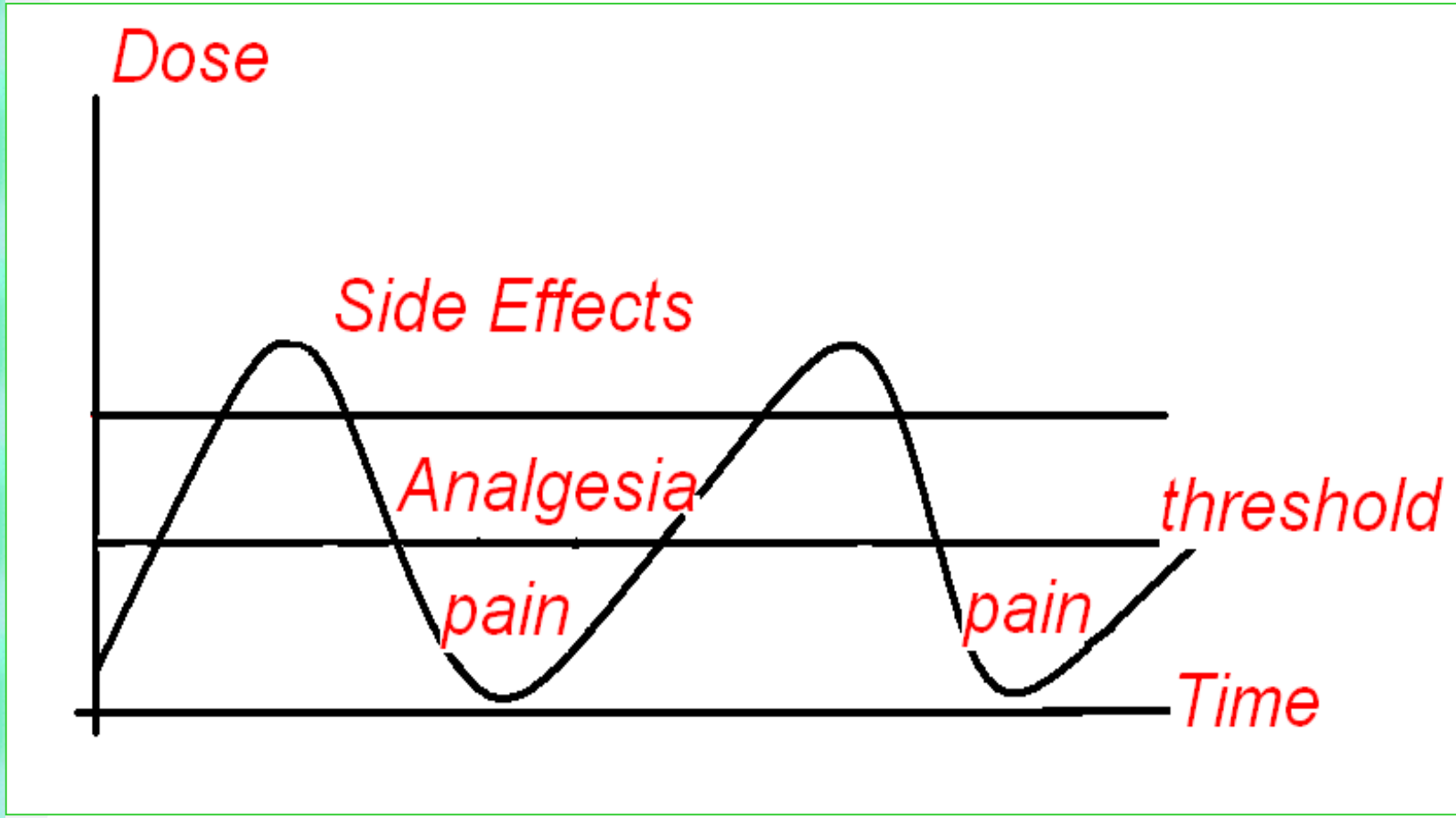
- **Examination & Explanation**
- **Modification of pathology**
- **Elevation of pain threshold**
- **Interruption of pain pathways**
- **Life style:modification / immobilisation**

Top 10 pains

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

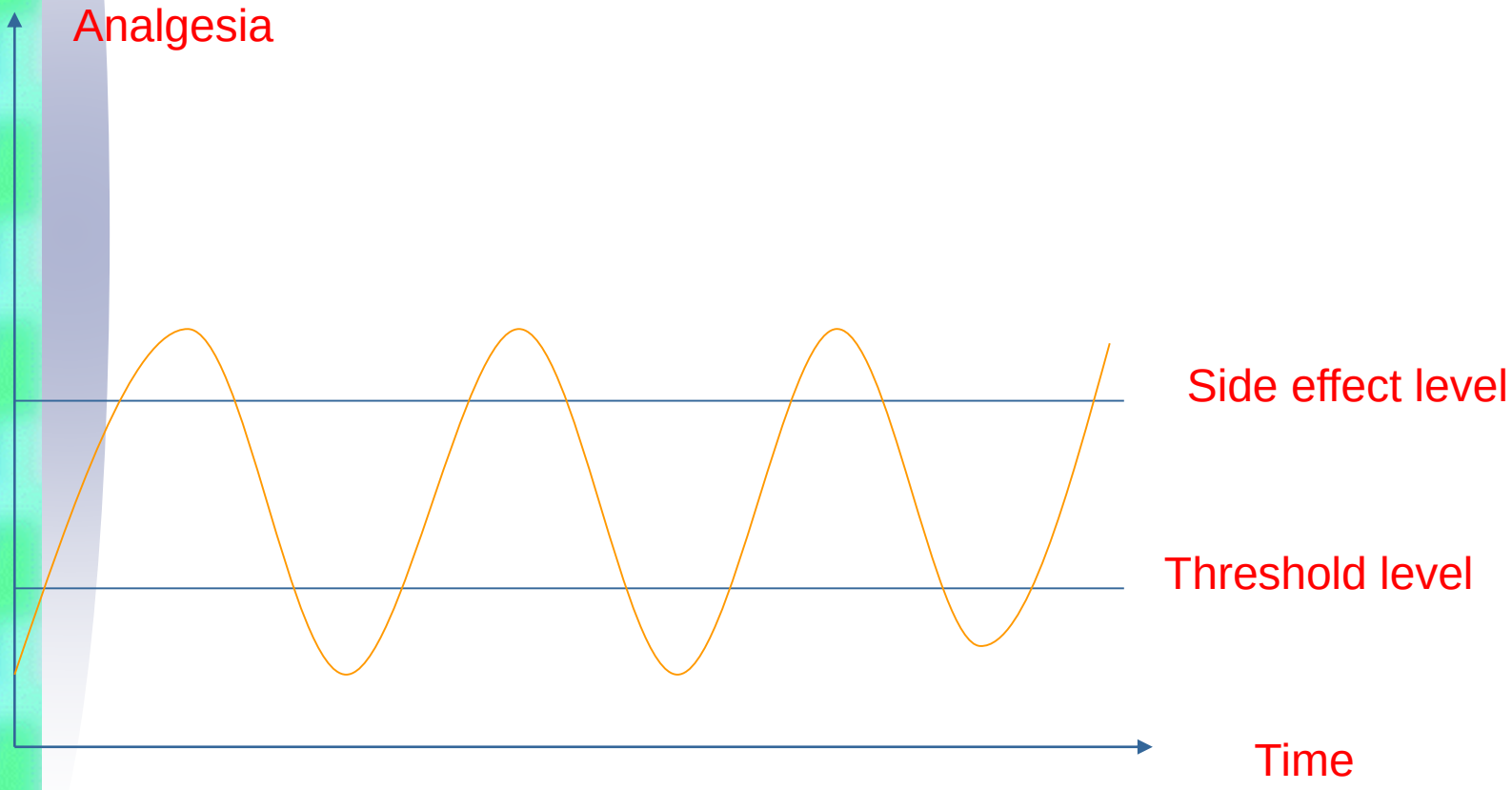
Emotional pain

- **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**


Dose
Side Effects
Analgesia
threshold
pain
pain
Time

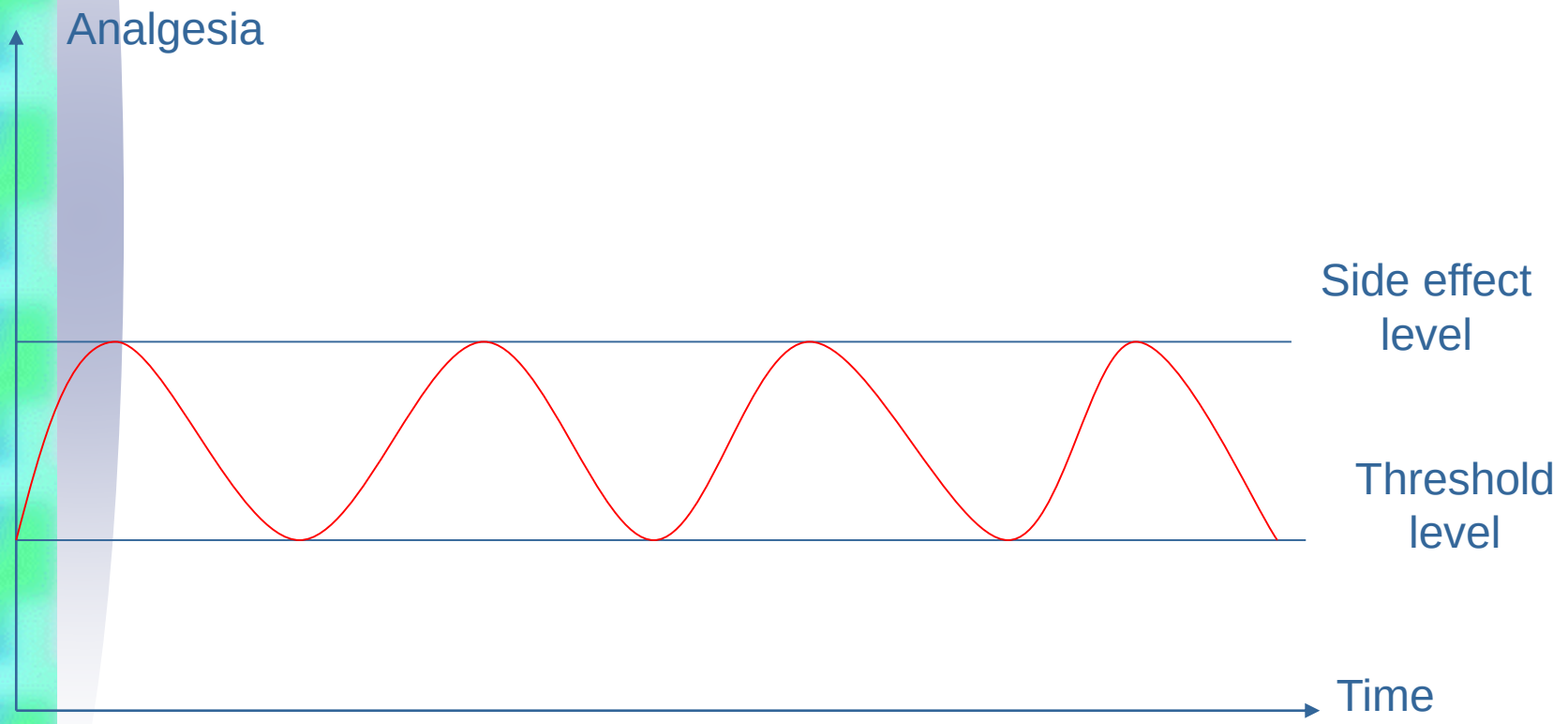
Pattern of pain

- **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**

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 چهارمیلیون نفرزندگی شان را از دست میدهند

در ۷۰% بیماران درمراحل پیشرفته درد ظاهر میشود

این نسبت در مرحله تر مینال به ۹۰%میرسد

هر روزقریب۸ میلیون نفر از درد ناشی از کانسر رنج میبرند

سندرمهای درد در بیماران کانسری

الف) ۷۷% در پی تهاجم توموروفشار آن به بافتهای حساس درد ایجاد میکنند

ب) ۱۹% دراثنای درمان مثل: شیمی درمانی / رادیوتراپی وجراحی 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 ودرمان میتواند درارتباط باشد.علت براحتی شناخته میشود.باظهور 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.بامشاهده 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 ورادیو تراپی ویاشیمی درمانی}

بیماران بادرد در حال مرگ:

اول از همه بایستی راحتی بیمار را فراهم کرد

Cancer pain management: Multidiscipliary approach

- **Primary anticancer treatment**
  - Oncologist
  - Radiation oncologist
  - Immunologist
  - Surgeon
- **Pain management: phrmacological/ procedural/ psychiatric/behavioral**
  - Anesthesiologist
  - Neurologist
  - Internist
  - Psychiatrist
  - Behavioral therapist
  - Physiatrist
- **Neuroinvasive therapy**
  - Neurosurgen
  - Anesthesiologist
- **General care**
  - Internist
  - Social worker
  - Family
  - Spiritual counselor
  - Psychiatrist
  - Physiatrist

ادامه درد

اپیوئیدهای قوی
نان-اپیوئیدها
اجونتها
ادامه پیدا میکنندیا جایش را
عوض میکنند

درد یکطرفه ویا لوکالیزه

بلوک راههای درد

تحت نظر گرفتن
مداوم درخانه یا
بیمارستان

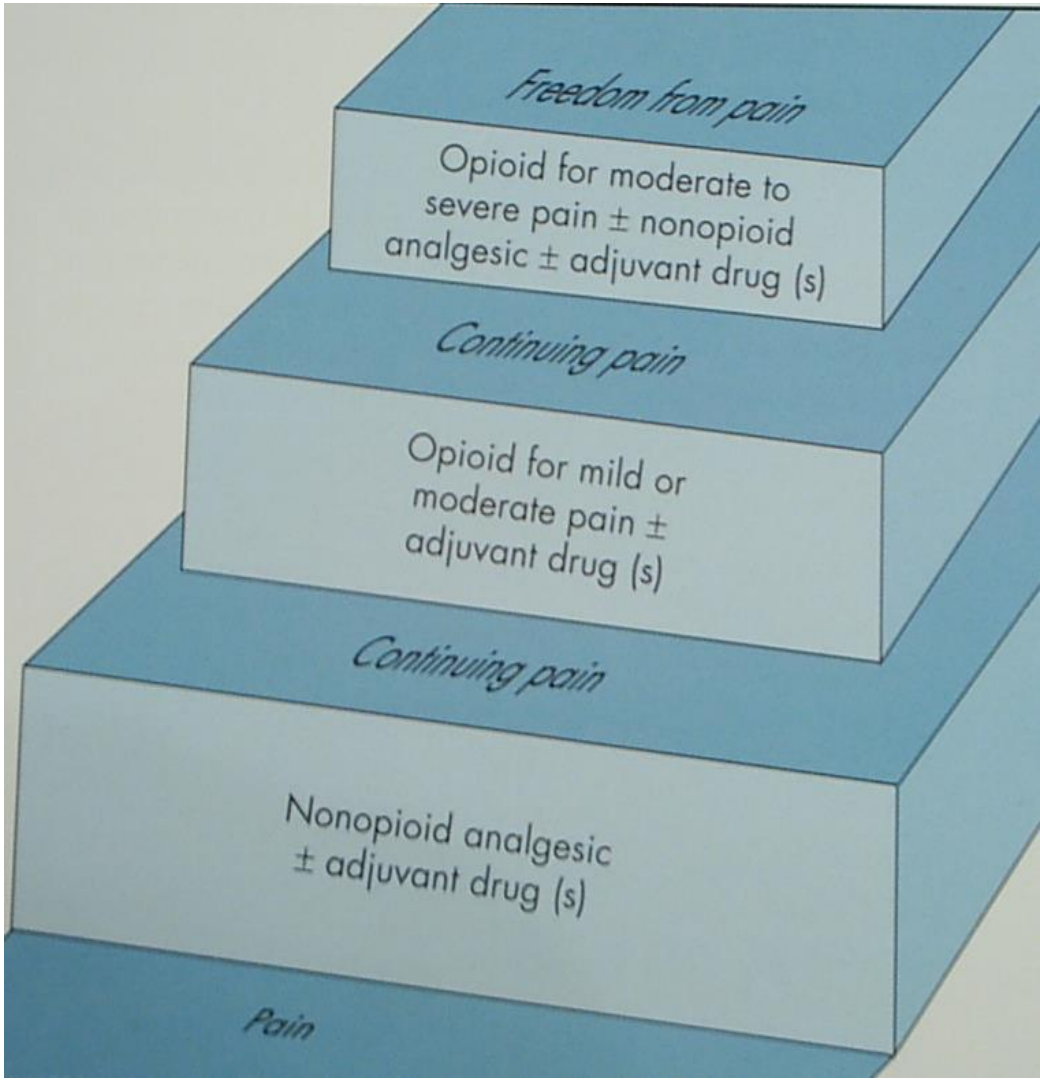
استراتژی درمان

اهداف:

مدت زمان خواب بیدرد را زیاد کند.

عدم احساس درد در حال استراحت.

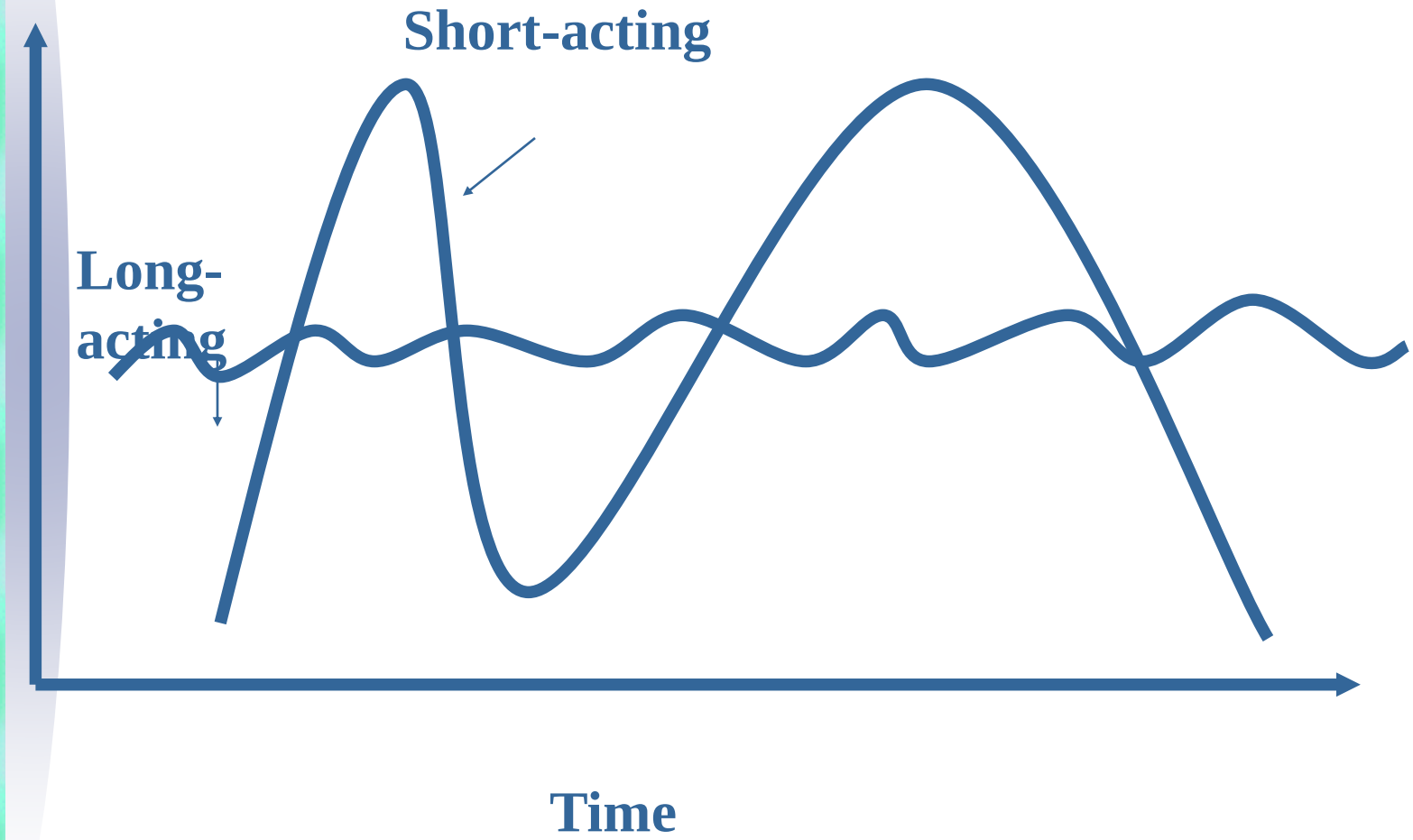
عدم احساس درد درزمان ایستادن وحرکت.



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
    - Sympathtic block
  - **Pitutary ablation**
  - **Cordotomy** (percutaneous ,open)
  - **Thalatomy**
  - **Electerical Stimulation of inhibitory centers**
  - **Biofeedback and relaxation techniqes**
  - **Physiatrics**
  - **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)

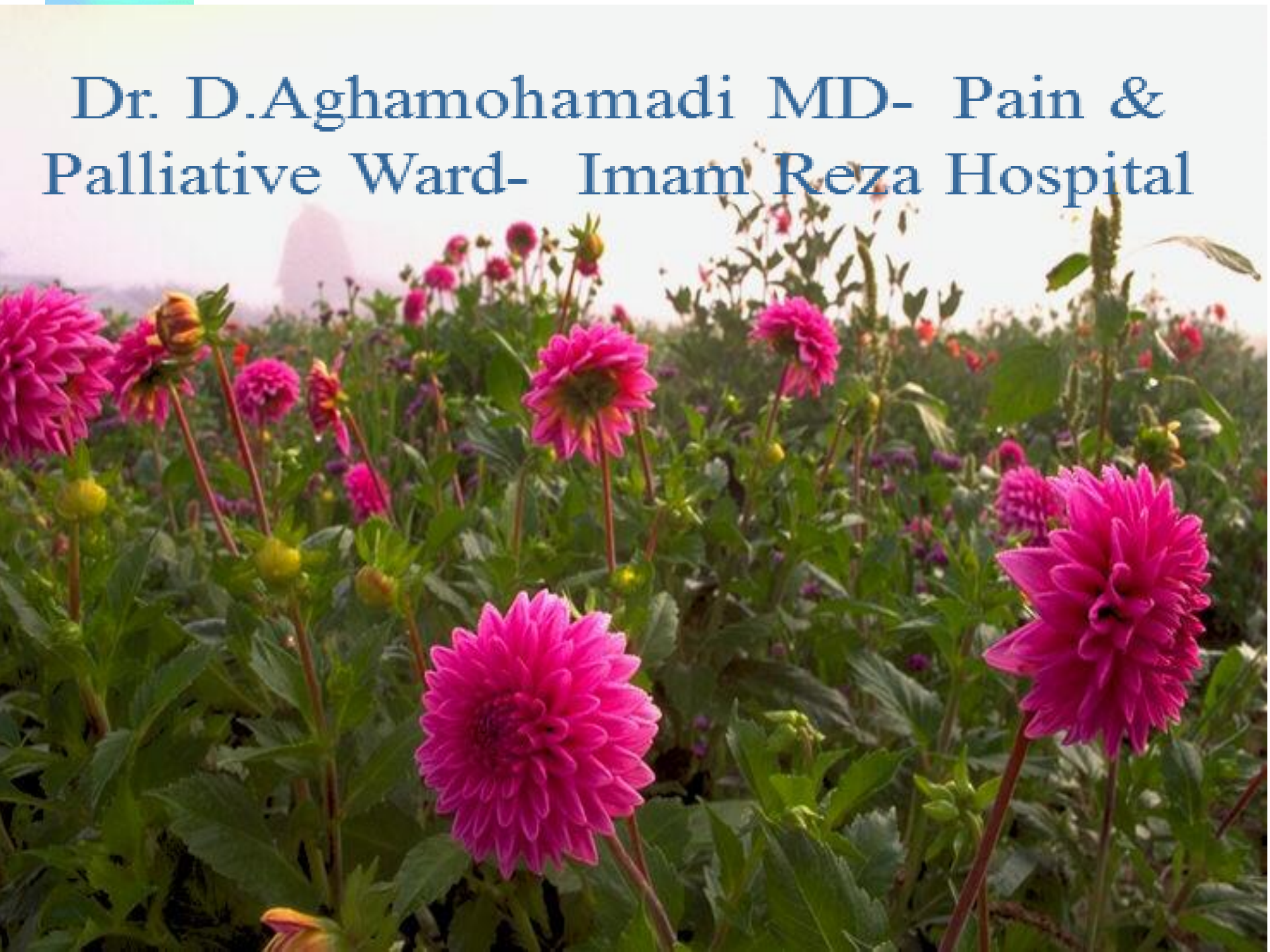
- **Diffuse cancer pain**
- **Osteoporosis**
- **Visceral pain**
- **Axial somatic pain**
- **Head & Neck pain**
- **Multiple sclerosis**

Indication for S.C.S

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

Indication for both of SAN & SCS

- **Rfelex 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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