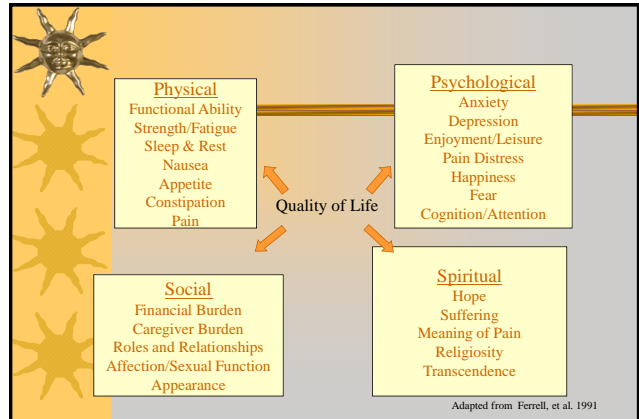


Symptom Management in the Terminally Ill

Katie Bond, RN, MPA, OCN



Developmental Landmarks and Taskwork for EOL

- * Sense of completion of worldly affairs
- * Sense of completion with relationships
- * Sense of meaning about ones' life
- * Experienced love of self
- * Experienced love of others

Developmental Landmarks and Taskwork for EOL

- * Acceptance of the finality of life
- * Sense of new self
- * Sense of meaning about life in general
- * Surrender to the unknown – “letting go”

Byock, I., “The Nature of Suffering and the Nature of Opportunity at the End of Life”.
Clinics in Geriatric Medicine, Vol. 12, No. 2, pp 237-251. May 1996.


Symptom Management Issues

- | | |
|--|--|
| <ul style="list-style-type: none"> * Physical - Pain 87% - Dyspnea 56% - Constipation 46% - Nausea and vomiting 27% | <ul style="list-style-type: none"> * Psychosocial - Family coping 43% - Stress 22% - Anxiety 15% |
|--|--|

*Weitzner, Michael et al *American Journal of Hospice and Palliative Care* July/August 1997


Symptom Management Issues

- | | |
|---|--|
| <ul style="list-style-type: none"> * Functional problem - Safety needs 82 % - Self-care deficit 63% - Caregiver needs | <ul style="list-style-type: none"> * Dying Well / Final Gifts * Five things of relationship completion - I forgive you - Forgive me - Thank you - I love you - Good-bye |
|---|--|




Definitions of Pain

- * "An unpleasant sensory and emotional experience associated with actual or potential tissue damage" Mersky 1979
- * "Whatever the experiencing person says it is, and whenever the person says it does" McCaffery, 1986




MYTHS

- * Comparable noxious stimuli produce the same intensity of pain in different people.
- * Changes in vital signs are reliable indicators of pain severity.
- * Patients can not sleep if pain is severe.
- * A placebo can be used to determine if pain is real.
- * Elderly patients cannot tolerate strong medications such as opioids for pain.




Barriers to Pain Management Clinician

- * Inadequate knowledge of pain management
- * Poor assessment skills - including developmental tasks
- * Concerns of physical dependence
- * Inappropriate attitudes




Equianalgesic Conversion Tables

- * Between Opioids and routes
- * Principle of conversion to "morphine equivalent does"
- * Use 24-hour total dosage or rescue attempts
- * Reasons for conversions: adverse effects, changing routes, cost, convenience, single agent consolidation
- * Individual response variation



Barriers to Pain Management Patients and Caregivers

- * Physical dependence is "...an altered physiological state produced by repeated administration of a drug..."
- * Addiction (psychological dependence) includes:
 - Compulsive use of drugs
 - Loss of control
 - Use in spite of harm
- * Tolerance is "... a common physiological result of chronic opioid use..."



Pathophysiology of Nociceptive Pain

- * Physiologic pain is caused by normal activation of primary afferent neurons –nociceptors
- * Inflammatory response in the peripheral nervous system after tissue damage
- * Example postoperative pain caused by surgical incision

Pathophysiology of Neuropathic Pain

- * Neuropathic pain arises from abnormal physiology of the peripheral or central nervous system
- * Neuropathic pain may be unrelated to ongoing tissue damage or inflammation

(Pasero, C. Pathophysiology of neuropathic pain, *Pain Management Nursing*, Vol. 5, No 4, December 2004; pp3-8)

Pain Physiology

- * Nociception: electrochemical events which occur between a site of tissue damage and the perception of pain
 - Transduction
 - Transmission
 - Modulation
 - Perception

Pain Physiology

Perception: transduction, transmission, and modulation are developed into subjective, sensory, and emotional experiences of pain

Types of Pain


- * Nociceptive
 - Somatic
 - Visceral
- * Neuropathic
- * Mixed

Pain Physiology

<ul style="list-style-type: none"> * Somatic pain <ul style="list-style-type: none"> - constant - well-localized - can be sharp * Visceral pain <ul style="list-style-type: none"> - tends to be poorly localized - dull, aching sensations 	<ul style="list-style-type: none"> * Neuropathic pain <ul style="list-style-type: none"> - Burning, numbness, sharp or shooting - Originates from nerve compression or stimulation - Serves no useful purpose - Usually sustained or chronic
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Assessment of Pain

- * Establish a baseline
- * Determine the cause
- * Select interventions
- * Evaluate response




Pain Assessment Components

- * Description
 - Quality
- * Location
 - Radiation
- * Temporal
 - Onset
 - Duration
- * Intensity
- * Alleviating factors
- * Exacerbating factors
- * Signs and symptoms associated with pain




Assessment of Pain in Cognitively Impaired/ Nonverbal

- * Change in baseline behavior
- * Discomfort indicator scale
- * Validate presence of pain
- * Observe and reassess after intervention
- * Limit drugs for restlessness




Medications

- * Acetaminophen
- * Non-Steroidal Anti-Inflammatories
 - Aspirin
 - Traditional NSAIDs
 - COX-2 Inhibitors




Medications (continued)

- * Opioids
 - Mild to moderate
 - Mixed
 - Strong
- * Neuropathic agents
 - Tricyclic and other antidepressants
 - Anticonvulsants
 - NMDA antagonists
 - Substance P depleters
 - Local anesthetics
 - Novel agents



Medications


- * Alternate routes/ least invasive
 - Oral
 - Rectal
 - Topical
 - Sublingual
 - Buccal



Definitions

- * Dyspnea – a person’s subjective awareness of altered or uncomfortable breathing
- * Terminal Dyspnea – the dyspnea experienced in terminal illness
- * Symptom distress – the physical or mental anguish and suffering that results from a nociceptive symptom *


* Rhodes et al. *Sem Onc Nsg*, 1987



Another definition


- * Respiratory distress – the observed corollary to dyspnea; the physical and/or emotional suffering that results from altered respiratory functioning that can be observed and measured*

* Campbell, *Crit Care Clinics N Am*, 2004




Dyspnea Assessment

- * Identify cause
- * Respiratory rate, depth and pattern
- * Auscultation
- * Coughing or choking
- * Cardiac
- * Self - report / rating scales




Dyspnea Drug Management

- * Opioids - decrease ventilatory response, decrease respiratory drive and rate, decrease cardiac preload, alter perception of breathlessness
- * Steroids - reduce airway obstruction, decrease inflammation
- * Bronchodilators - relax bronchial smooth muscle
- * Benzodiazepines - reduce anxiety




Dyspnea Nonpharmacological management

- * Oxygen
- * Counseling
- * Pursed lip breathing
- * Energy conservation
- * Fans, elevation
- * No perfumes or scents




Cough

- * Present 39-80% of palliative care patients
- * Causes pain, fatigue, reminder of decline
- * Assess underlying cause
 - Infection
 - Sinusitis
 - Reflux




Cough

- * Pharmacologic interventions
 - Suppressants
 - Expectorants
 - Antibiotics
 - Steroids
 - Anticholinergics




Cough

- * Non-pharmacological
 - Chest Pt
 - Humidifier
 - Elevate head of bed
 - Fluids
 - Caffeinated beverages




Nausea and Vomiting

<ul style="list-style-type: none"> * Visceral (Vagal) <ul style="list-style-type: none"> - Gastric irritation - Abdominal cancer - Intestinal obstruction - Constipation - Liver disease - antineoplastic drugs 	<ul style="list-style-type: none"> * Chemical, Blood, CSF (CTZ) <ul style="list-style-type: none"> - drugs - opioids - antineoplastic - metabolic / biochemical toxins - SIADH
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Nausea and Vomiting


<ul style="list-style-type: none"> * Vestibular <ul style="list-style-type: none"> - Motion and position sickness - ototoxic drugs - Acoustic neuroma 	<ul style="list-style-type: none"> * Other <ul style="list-style-type: none"> - Pain - Emotional- anxiety , fear, - Odors - Uncontrolled cough - CNS cancer - Increased ICP
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Treatment Nausea and Vomiting


- * Visceral - bowel management; Antihistamines, dopamine antagonist; H2 blockers
- * Vestibular - antihistamine or Anticholinergics
- * Chemicals - dopamine antagonist, H2 blockers
- * CNS - corticosteroids, antihistamine
- * Non - pharmacological - patient focus
- * Patient and family perceptions and information
 - Intake cessation
 - Meaning of food
 - Starved to death

Mearse, ONF vol. 24, no. 10 1997




Constipation

- * Defined as the Infrequent passage of stool
- * Associated with rectal pressure, straining, distension, and sensation of bloating
- * Causes intestinal obstruction
- * Hypercalcemia or hypokalemia
- * Dehydration
- * Inactivity
- * Prevention is key




Constipation

<ul style="list-style-type: none"> * Assessment <ul style="list-style-type: none"> - Bowel history - Abdominal assessment - Rectal assessment - Medication review 	<ul style="list-style-type: none"> * Treatment <ul style="list-style-type: none"> - Medication - Dietary and fluids
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Diarrhea

- * Defined as the frequent passage of loose non-formed stools
- * Causes
 - Aids
 - Partial bowel obstruction of fecal impaction
 - Malabsorption with pancreatic tumors or gastrectomy




Diarrhea

<ul style="list-style-type: none"> * Pharmacological interventions <ul style="list-style-type: none"> - Opioids - Bulk-forming agents - Antibiotics - Steroids - Somatostatin 	<ul style="list-style-type: none"> * Nonpharmacological <ul style="list-style-type: none"> - Fluids - Environment
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Fatigue

- * Definition; The awareness of a decreased capacity for physical and / or mental activity.
- * 60-99 % of cancer patients state infers with QOL
- * Compounded by other diseases – ESRD, RA, CAD, HIV




Fatigue

- * Management
 - Lack of information
 - Improve disrupted sleep pattern
 - Deficient nutritional status
 - Distraction / restoration
 - Decreased energy needs
 - Physical limitations
 - Symptom management



Symptoms at the EOL

- * Anorexia
- * Cachexia
- * Hiccups
- * Ascites
- * Incontinence
- * Bladder spasms



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