Symptom Assessment And Management For FLW

COMPETENCY

For MPWs and ASHAs

- Demonstrate an awareness about the common medications used in Palliative Care including essential opioids.

- Demonstrate an awareness about the role of non-pharmacological interventions in Palliative Care including essential opioids

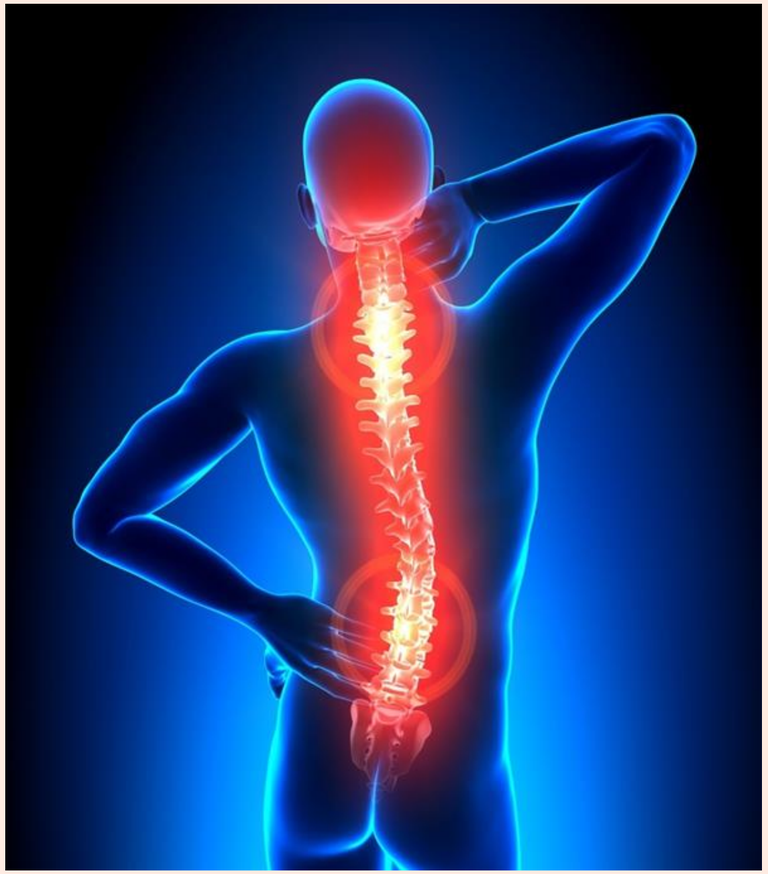
LEARNING OBJECTIVES

For MPWs and ASHAs

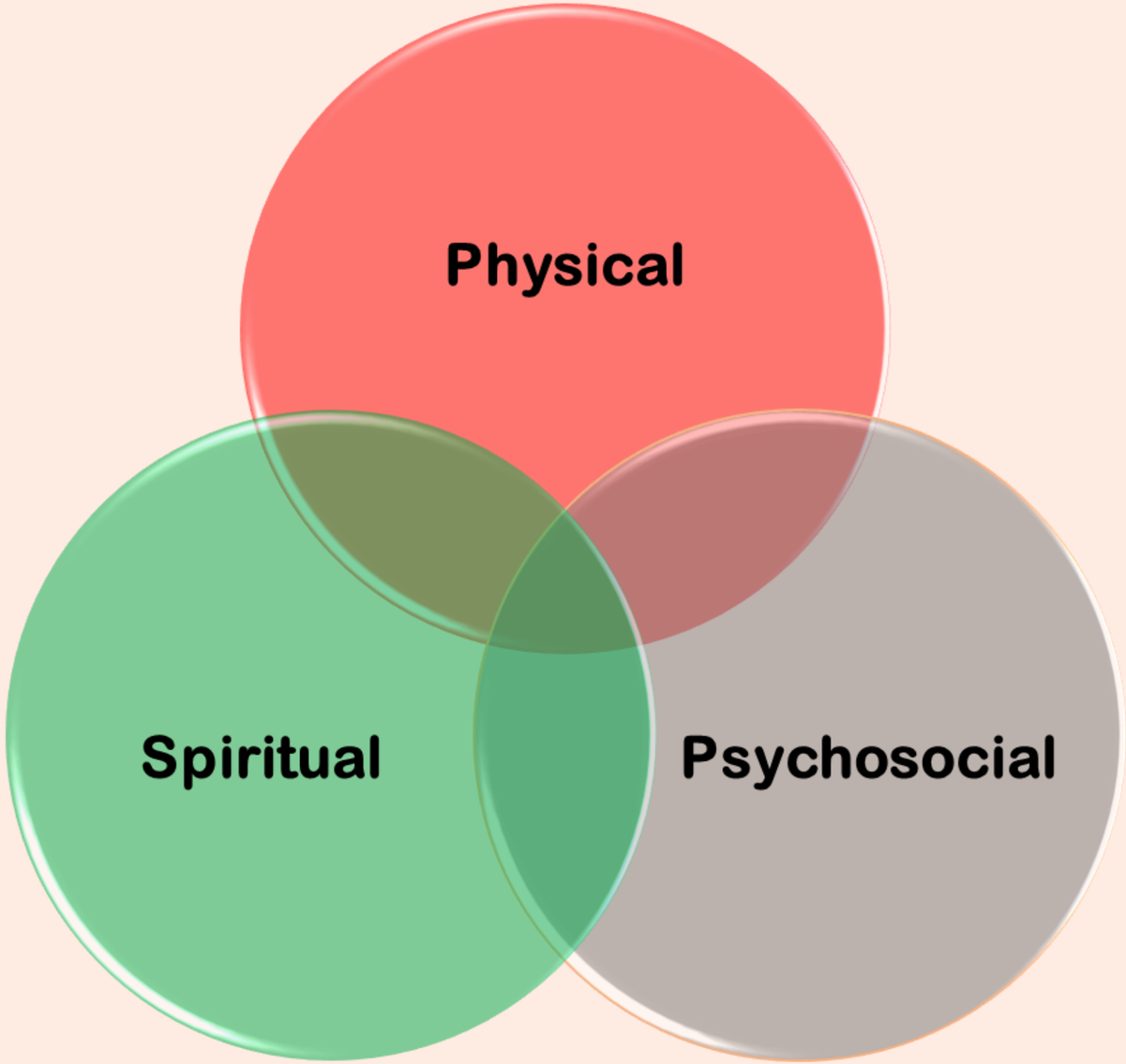
- List common medications used in home care including opioids.
- Describe non-pharmacological interventions for management of common symptoms [Pain, Nausea and Vomiting, Breathlessness, Constipation]
- Enumerate common adverse effects of Morphine.
- Discuss advice to be given to a patient [and their family] who is on Morphine.

DEFINITION

- Pain is an unpleasant experience because of actual or likely damage to tissues.
- It is subjective and varies from person to person.
- It is both a physical and emotional response



DIMENSIONS OF TOTAL PAIN



PAIN

- Common symptom of many advanced, potentially incurable diseases
- CRF, CHF, COPD,HIV- 40-80% patients have pain
- 70% of advanced cancer patients experience pain
- Pain is unrecognized, unacknowledged and undertreated throughout the world

ACUTE AND CHRONIC PAIN

ACUTE PAIN

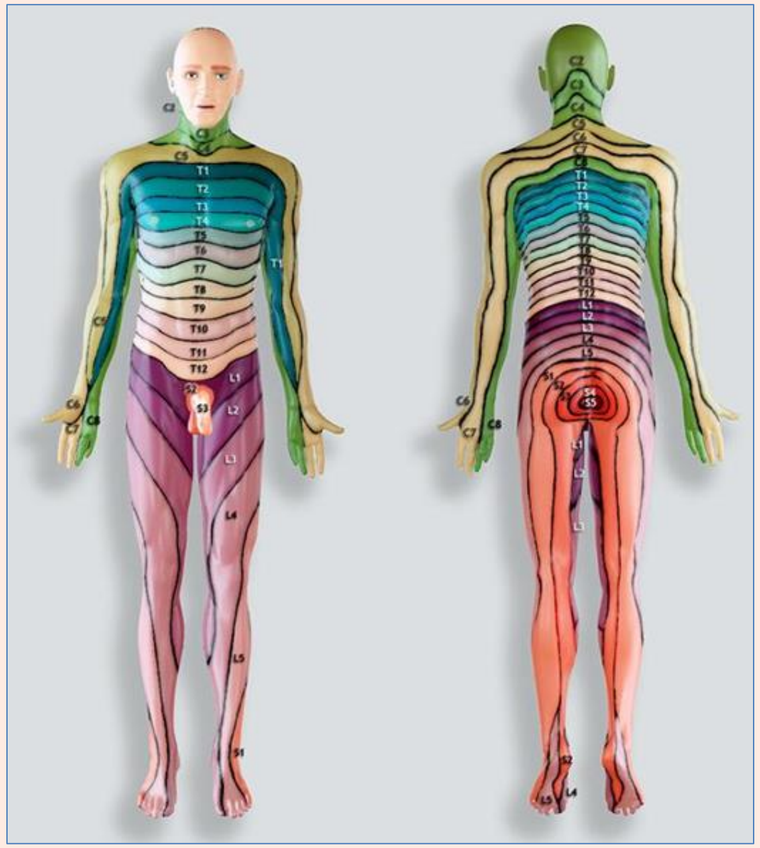
- Temporary
- Indicates injury
- reduces as healing occurs
- Tells body that protection of injured part is needed
- Redness, swelling , reduced movement of part
- Person with pain is restless, crying, rolling around
- Treated with medicines and injections as and when needed

CHRONIC PAIN

- Persistent > 3 months
- Permanent changes in body
- Person with pain is quiet, withdrawn
- Decreased appetite, sleep, sex drive, social interaction, interest in surroundings
- Constant reminder of life- limiting illness becomes a disease in itself
- Needs prevention and round the clock medicines
- Injections avoided
- May need to increase dose and frequency as disease progresses- does not mean Person with pain is addicted
- Combinations of drugs may be needed

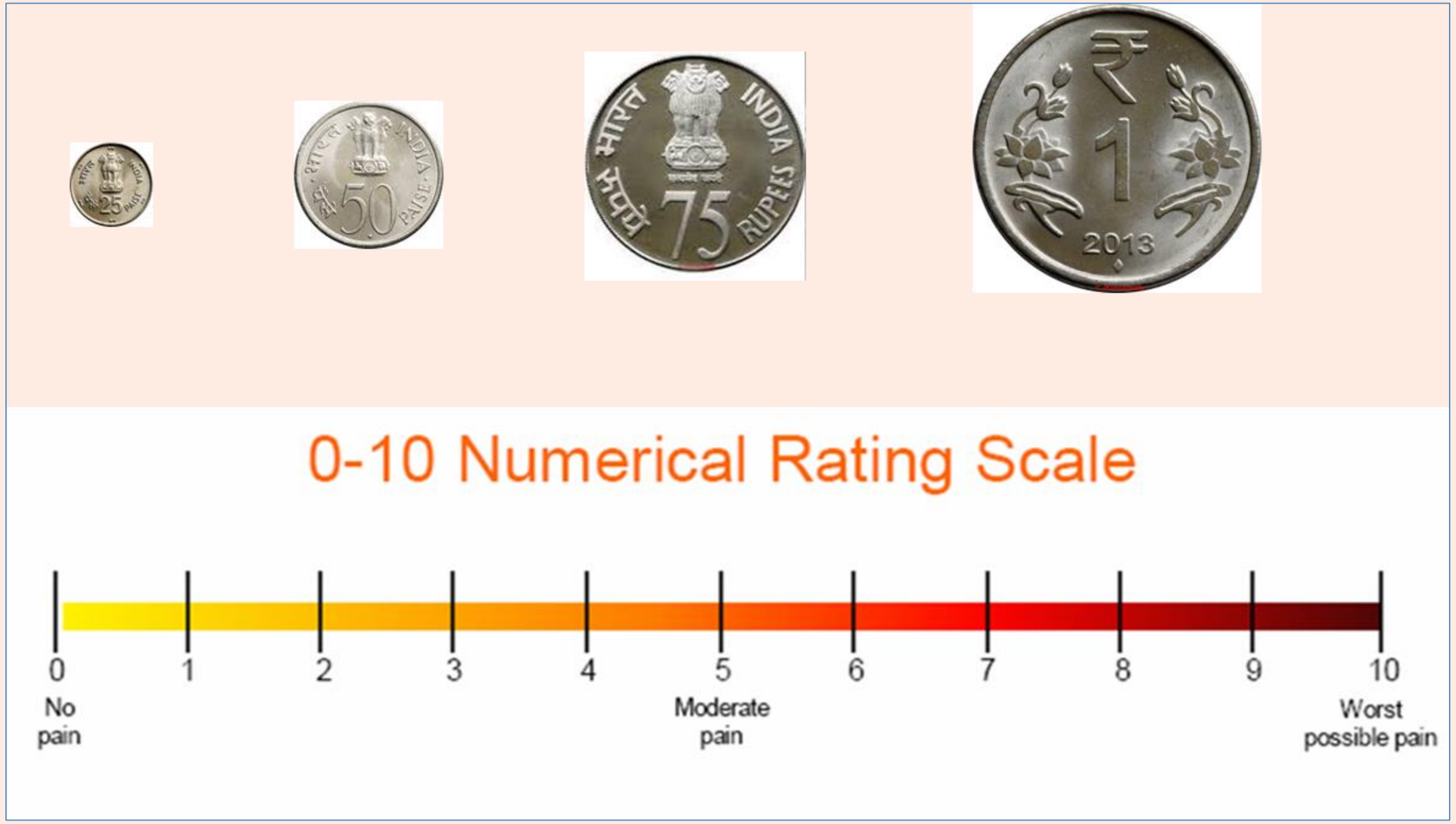
PAIN ASSESSMENT

PQRST: CHARACTERISTICS OF PAIN	
QUESTIONS TO ASK	
P Palliative factors Provocative factors	What makes pain better? What makes pain worse?
Q Quality	Describe the pain
R Radiation/ Region	Where is the pain? Which area of the body is affected?
S Severity	How does the pain compare with other pain you have experienced?
T Temporal factors	Does the intensity of pain change with time?

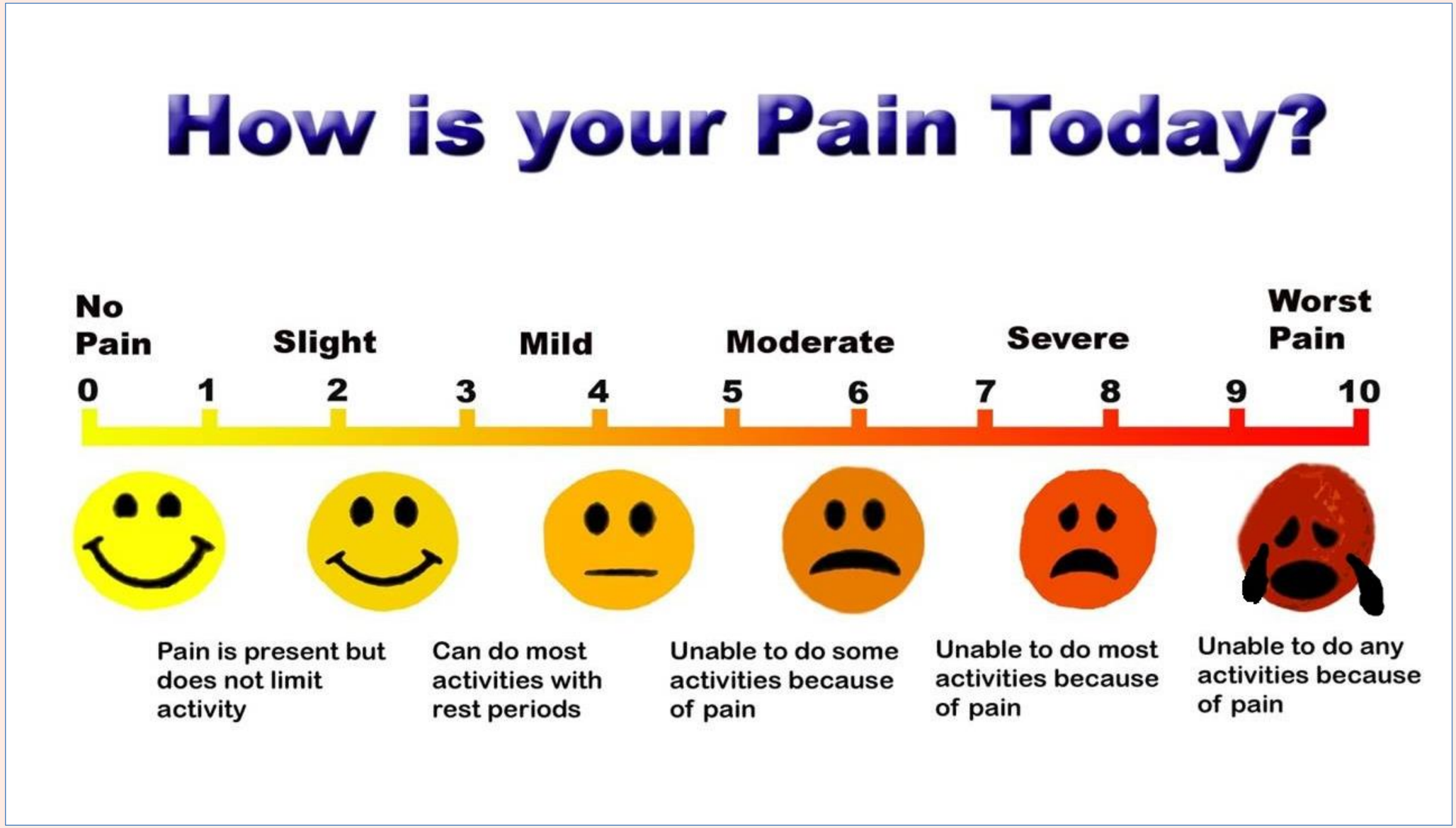


PAIN RATING SCALES

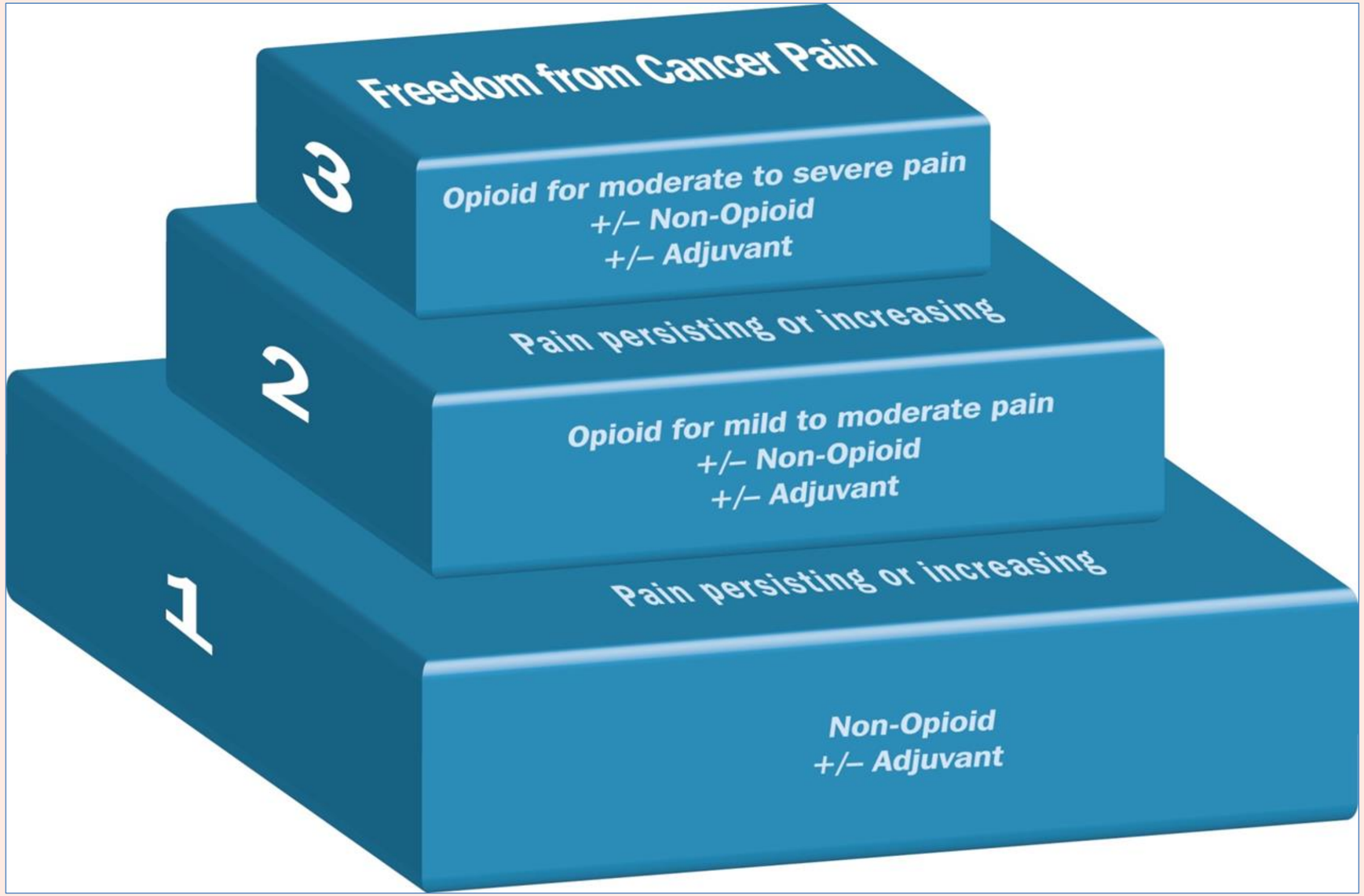
Rupee Scale- how many paise in a rupee is your pain? 25 p, 50 p, 75 p or Rupee/ Rupee



UNIVERSAL PAIN SCALE



WHO ANALGESIC LADDER



DRUGS IN WHO LADDER

STEP I NON-OPIOIDS	STEP II WEAK OPIOIDS	STEP II STRONG OPIOIDS	ADJUVANTS/ CO-ANALGESICS
• NSAIDS e.g. Paracetamol, Diclofenac and Ibuprofen	• Tramadol • Codeine	• Morphine • Buprenorphine • Fentanyl • Methadone	• Anti-emetics • Anti-depressents • Anti-convulsants • Muscle relaxants • Antibiotics • Anxiolytics • Sedatives • Antacids

WHEN ON PAIN MEDICINES

- Very important to review them regularly to
  - find out the exact dose needed and
  - to check for side effects.
- Medicines for chronic pain must be given:
  - By the Clock – Regular intervals, not prn/SOS
  - By the Mouth – Safe, cheap and convenient
  - By the Ladder – Proven method to control 90% of pain

FACTS

- Pain relief is a fundamental human right
- Denial of pain relief is tantamount to torture
- 6 countries (Australia, Britain, Canada, France, USA and Germany) consume 80% of the morphine
- Poorer nations with 80% population consume only 6%
- India is the largest morphine producing country
- On WHO list of essential medicines since 1985
- Domestic consumption very little in spite heavy burden
- Mostly exported
- Lack of demand -unwarranted fears of abuse, addiction
- Cheap
- Stringent, outdated regulations

MORPHINE- GOLD STANDARD FOR SEVERE CHRONIC PAIN

- Safe drug if used by trained personnel
- Needs to be used carefully and patients must be under supervision.
- Can be in the form of injections, tablets, suspension or rectal suppository
- Tablet or syrup preferred for chronic cancer pain.
- Not the first choice for chronic, non -cancer pain.
- Trained Medical officer can prescribe oral morphine

No upper limit in pain treatment

OBSTACLES TO ADEQUATE PAIN CONTROL

- Lack of education and knowledge
- Fears of addiction
- Legal barriers to drug availability
- Patient’s reluctance to take opioids
- Dosing and side effects
- Patient’s reluctance to communicate pain

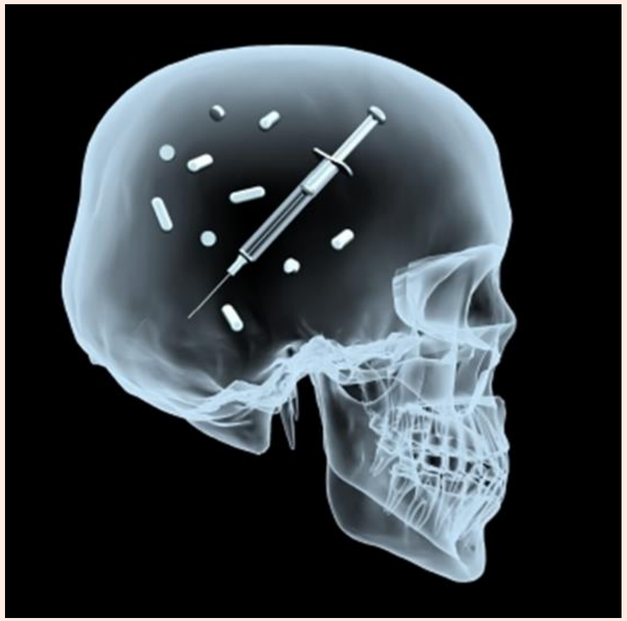
PROFESSIONALS MYTHS

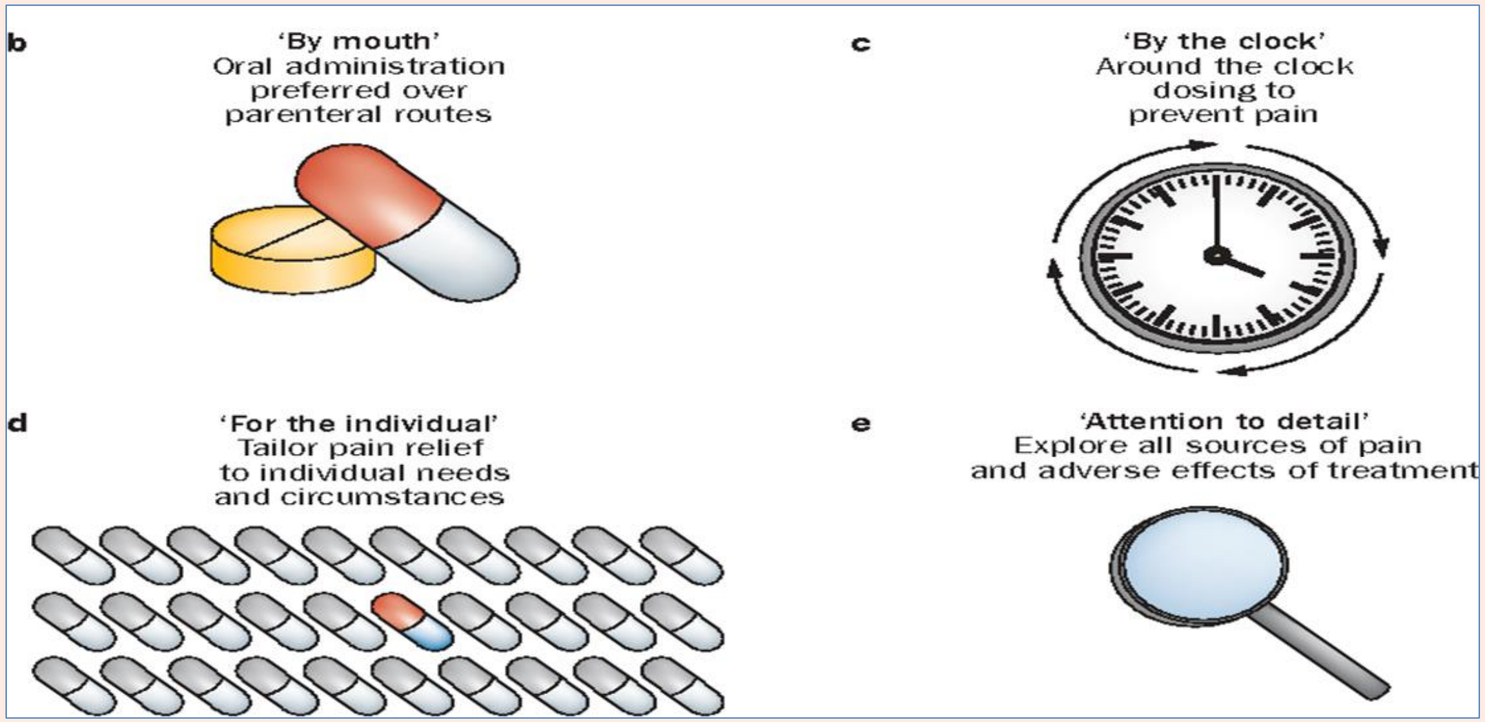
MORPHINE

- should be used only when the patient is dying
- hastens death
- causes respiratory depression
- causes unacceptable side effects
- Fear of addiction

ADDICTION

- Rarely occurs in patients receiving morphine for medical purposes
- Fear of addiction –important factor in under-dosing

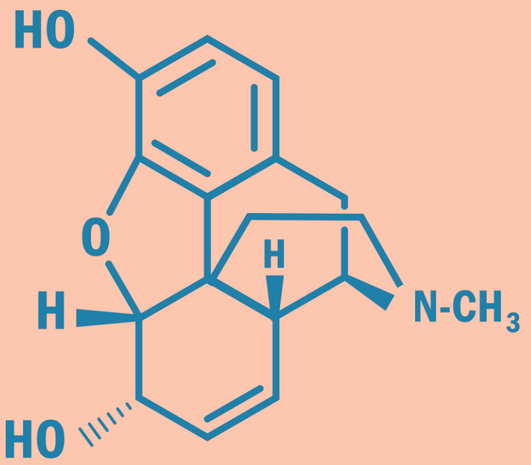




- Given according to intensity and type of pain, not stage of disease
- Immediate release preparations used first
- Started low 5-10 mg, every 4 hrs and titrated till pain relief or intolerable side effects
- Sustained pain relief achieved
- Changed to slow release preparations only after pain relief is stable
- Common side effects prophylactically covered
- Review regularly

SIDE EFFECTS OF MORPHINE

- Constipation - Laxative prescribed must always be used in correct dose
- Nausea/vomiting
- Urinary retention
- Itch/rash - antihistamines are not very helpful.
- Dry mouth- Give sips of water frequently.
- Respiratory depression – uncommon when titrated properly
- Neurotoxicity- can have muscle jerks rarely



Morphine

REFER

NON-PHARMACOLOGICAL (NON-DRUG) METHODS FOR MANAGING PAIN

- Physiotherapy
- Hot and cold packs
- Massage
- Proper positioning
- Reassurance
- Diversion therapy
- Art or music therapy
- Acupressure and Acupuncture

- 40 year old man diagnosed with cancer of the mouth,

- History of chewing tobacco for 40 years,

- Persistent pain over the jaw which has become severe since few weeks, and not getting relieved by the medications prescribed by the local doctor. He has foul smelling wound over the jaw and has not slept well for several weeks due to pain.

- He is a carpenter and now unable to work due to illness.

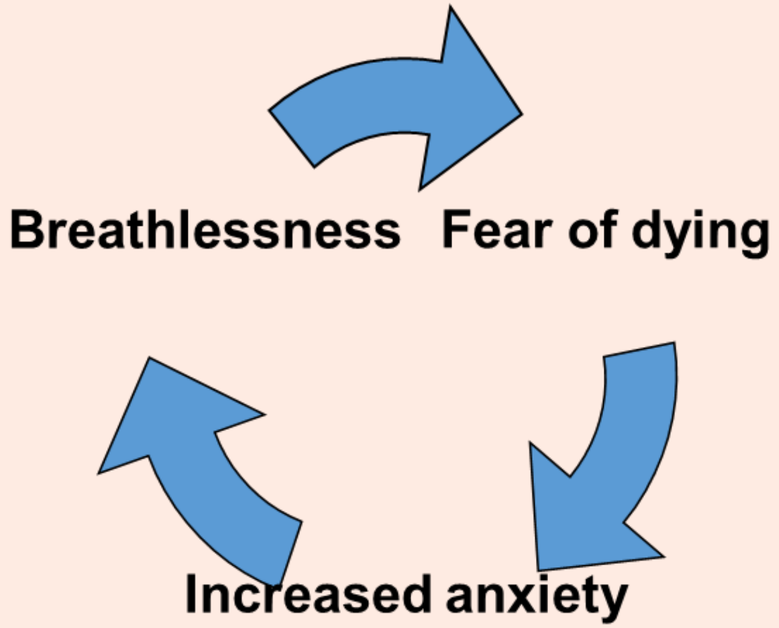
- How does it affect his life?

- How will you help him?

RESPIRATORY SYMPTOMS- BREATHLESSNESS

- Breathlessness occurs in almost half of the patients referred for palliative care.
- It can be very frightening.
- It restricts activities.
- There is loss of independence, frustration, anger and depression.

ANXIETY -BREATHLESSNESS VICIOUS CYCLE



- Breathlessness at rest can cause anxiety and panic attacks.
- Patients often fear suffocating to death. Explanation and support are important.

CAUSES

Some causes are reversible eg wheezing due to tightening of airways. It can be made better with medicine given by doctor.

APPROACH - SOME CAUSES ARE REVERSIBLE

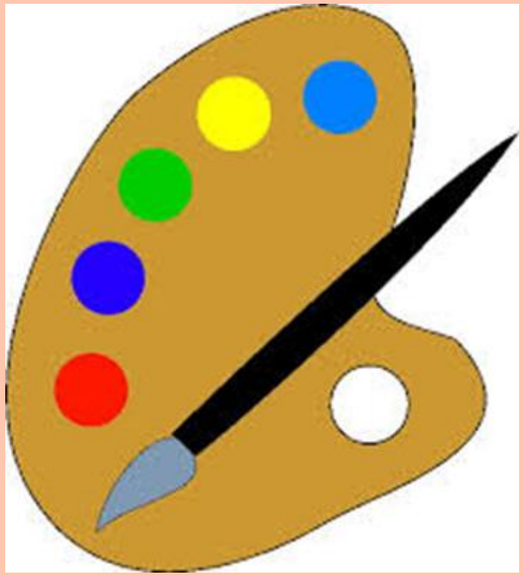
- Example: Wheezing due to tightening of airways. It can be made better with medicines given by the doctor.
- **Check if the patient has been given any drugs or nebulizer earlier**
- Morphine is very helpful in decreasing breathlessness by acting on various centres in the brain.
- Oxygen may help in few cases where there is less oxygen in the blood but in cases where the lungs are destroyed by the disease, it may not help

NON- DRUG MANAGEMENT

- Prop up with pillows or back rest
- Ensure good ventilation
- Flow of air across face
- Calm environment
- Avoid tight clothes
- Keep mouth moist
- Wipe face with wet towel
- Hand held fan

NON- DRUG MANAGEMENT

- Discuss worries, explain
- Complementary therapy: art, music
- Distraction techniques
- Physiotherapy and breathing exercises
- Relaxation therapy
- Activity pacing



DIAPHRAGMATIC BREATHING

- Relax the shoulders and upper chest
- Breath deeply feeling abdominal wall move out
- Massage by care giver from behind helpful, provides psychological support
- Needs to be taught before an acute episode

PURSED -LIP BREATHING

- Nasal inspiration followed by expiration through partially closed lips
- Expiration taking twice as long as inspiration

DISTRESSING BREATHLESSNESS DURING DYING

PLAN FOR THIS WITH THE TREATING DOCTOR

- NO PATIENT SHOULD SUFFER LIKE THIS

ADVISE FAMILY ON EMERGENCY MEDICINES

- THERE ARE MEDICINES THAT HELP

REASSURE AND SUPPORT

GROUP ACTIVITY

- Ram Kumar, a 35-year-old beedi worker, and father of three children, was diagnosed with advanced lung cancer.

- He has severe breathlessness for many days.

- He has been bedbound and anxious since any kind ofexertion worsens his breathlessness.

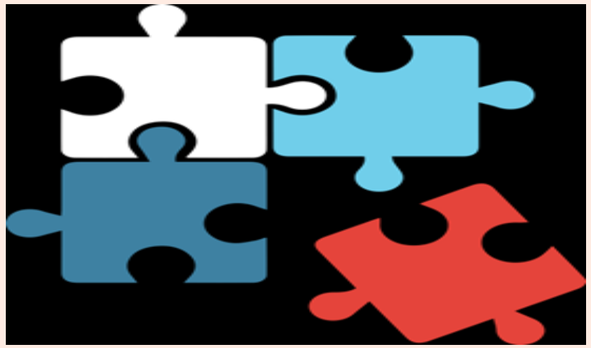
1. What makes him think he cannot get up?
2. How does fear cause breathlessness?
3. How can you help the family and the patient?

NAUSEA AND VOMITING

- Nausea is an unpleasant feeling of the need to vomit
- Vomiting is the forceful throwing out of stomach contents through the mouth.
- Nausea causes more misery than vomiting.

NON-PHARMACOLOGICAL (NON-DRUG) MANAGEMENT OF NAUSEA AND VOMITTING

- **A calm, reassuring environment** away from the sight and smell of food
- **Avoid exposure** to foods which precipitate nausea
- **Small frequent meals**
- **Cold food** is tolerated better than hot food
- **Control of bad smell e.g.** from wound measures



ROLE OF MPW

- Identification of terminally ill patients
- Reporting to CHO
- Home visits with basic care of dying
- Education of family about basic technique in care
- Provision of essential drugs
- Retrieval of unused opioids after death

ACTIVITY

- A 65 yr old lady with advanced cancer of breast has just come back to village after treatment from the city by bus. She has a smelly wound on chest. She cannot eat or sleep due to pain.

- She is having vomiting for the past three days. She is on many pain medications.

- What could be the reasons for vomiting?

ACTIVITY

- A 12 year old child with blood cancer starts vomiting as soon as he enters the hospital gate.

- What could be the cause?

CONSTIPATION

- Constipation is the difficult or painful passing of stools, less number of stools which are hard.
- About 45% of palliative care patients are constipated.
- It can cause bloating and rectal fullness, loss of appetite, abdominal pain, bowel obstruction, overflow diarrhoea and urinary retention

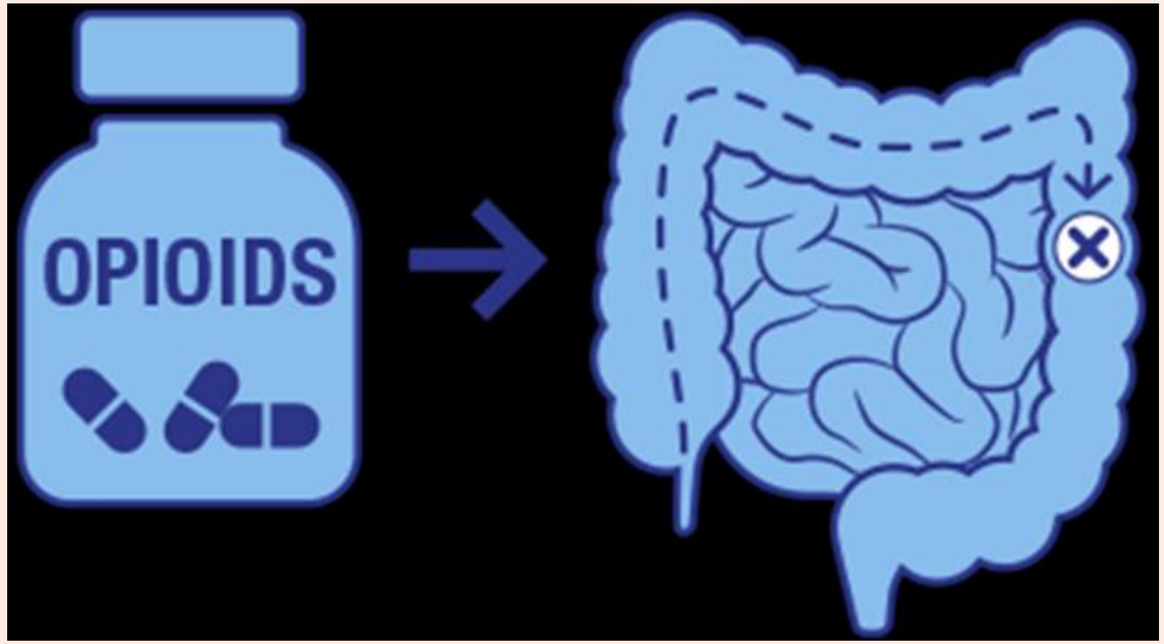
CAUSES OF CONSTIPATION IN PALLIATIVE CARE

- Immobility leading to decreased peristalsis
- Decreased food intake, low fibre diet
- Poor fluid intake or increased fluid loss (vomiting, diarrhoea)
- Inability to raise intra-abdominal pressure (general weakness, paraplegia)
- Inability to reach toilet in time
- Opioids (90% of patients taking opioids need laxatives)
- Embarrassment in public place
- Pain (fissure in anal area)

OPIOIDS AND CONSTIPATION

Common cause in palliative care

- Both (injection and tablet) opioids cause constipation
- 90% of patients taking opioids need laxatives
- Prevention is better than cure



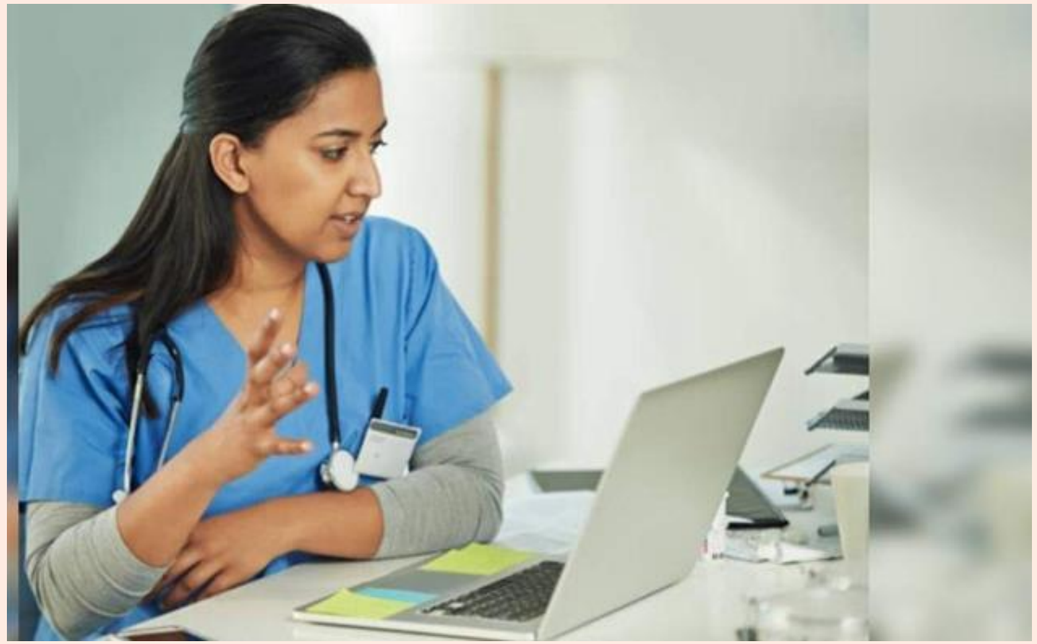
“The hand that prescribes Morphine should always prescribe laxatives”

NON-PHARMACOLOGICAL (NON-DRUG) MANAGEMENT OF CONSTIPATION

- Being able to get to the toilet may be more important than laxatives
- Timing and privacy
- Straining damages pelvic muscles
- A squatting position helps
- Encourage a normal balanced diet and drink plenty of fluid, (but this may not be possible in palliative care patients).

DRUG MANAGEMENT

CONSULT THE DOCTOR



DIARRHOEA

- Passage of more than 3 loose stools in 24 hours.
- Patients can understand “diarrhea” in different ways so always clarify.
- Diarrhea is less common than constipation
- Common causes :
  - Imbalance of laxative therapy - commonest cause.
  - Drugs (antibiotics, pain medications)
  - Faecal impaction may be due to fluid stool which leaks past a faecal plug or a tumour mass (“overflow diarrhoea”)
  - Change in diet

MANAGEMENT

- Increase fluid intake- frequent sipping of water/ Home-made ORS/ Dal water/ Lemon water/ Coconut water

- Reassurance that most diarrhoea is self-limiting.

- If severe - consult the doctor

EVALUATION

STATE IF TRUE OR FALSE

1.If a palliative person has chronic pain, we must give pain medications SOS – T/F

2.Morphine helps with pain and breathlessness – T/F

3.Propping a person up helps a palliative person with breathlessness T/F

4.Nausea can be managed with a fan blowing breeze on the face of a patient T/F

5.Constipation is more common than diarrhoea in palliative care patients T/F

EVALUATION

STATE IF TRUE OR FALSE

1. If a palliative person has chronic pain, we must give pain medications SOS – T/**F (round the clock)**

2. Morphine helps with pain and breathlessness – **T**/F

3. Propping a person up helps a palliative person with breathlessness **T**/F

4. Nausea can be managed with a fan blowing breeze on the face of a patient **T**/F

5. Constipation is more common than diarrhoea in palliative care patients **T**/F

MATCH THE FOLLOWING

S.NO	CONTENT	S.NO	CONTENT
1.	Non drug management of pain	a	Squatting position
2.	Non drug management of vomitting	b	Frequent sips of water
3.	Non drug management of diarrhoea	c	Wipe face with wet towel
4.	Non drug management of constipation	d	Massage
5.	Non drug management of breathlessness	e	Cold food

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5.	Non drug management of breathlessness	e	Cold food
	1-d, 2-e, 3-b, 4-a, 5-c		

Thank You