

Common Symptoms For MO





OUTLINE

- **Assessment**
- **Approach**
- **Nausea and Vomiting**
- **Breathlessness**





Symptoms at the end of life



Pain	67%
Trouble breathing	49%
Nausea and vomiting	27%
Sleeplessness	36%
Confusion	38%
Depression	36%
Loss of appetite	38%
Constipation	32%
Bedsore	14%
Incontinence	33%



Seale and Cartwright, 1994, *The Year Before Death*, Avebury, UK



What Do Patients with Serious Illnesses Want?

- Control of pain and other symptoms
- A sense of control
- Relief of burdens on the family
- Strengthen relationships with loved ones
- (Avoid inappropriate prolongation of dying)

Singer et al. 1999, *JAMA*;281(2):163-168.



EDMONTON SYMPTOM ASSESSMENT SCALE

- Pain
- Nausea
- Fatigue
- Dyspnoea
- Well being



- Depression
- Anxiety
- Drowsiness
- Appetite
- Other : constipation



Worst Possible
Lack of Appetite

GENERAL PRINCIPLES-EEMMA

- Evaluation - Diagnosis of each symptom
- Explanation - Before starting treatment
- Management - Individualised treatment
- Monitoring - Continuous review
- Attention to detail - Avoid assumptions



SYMPTOM MANAGEMENT

Principles

- Believe the patient
- Take a careful history
- Establish diagnosis with relevant examination and investigation
- Institute treatment specific to diagnosis
- Set goals
- Remember holistic approach
- Re-evaluate and adjust





EVALUATION

- Listen
- Careful history
- Remember each symptom
- Examination and investigation as appropriate





EVALUATION - OPQRSTUV

- O Onset
- P Palliating(alleviating)/provocative factors
- Q Quality
- R region/radiation
- S Severity
- T Time
- U Understanding (patient's understanding)
- V Value (priority to the patient)



EXPLANATION

- Results of evaluation
- Reasons for treatment
- Understanding of patient and family
- Fears and worries
- Explain prescription, rescue doses etc





MANAGEMENT

- Individualise
 - Agree joint goals
 - May not be physical
 - Depends on resources
 - Good communication essential
 - Non-compliance very common
 - Traditional beliefs, doctors assumptions
 - Family





ATTENTION TO DETAIL

- Be inquisitive
- Relatively small issues may make big difference
- Ensure treatment is effective
- Avoid doing harm





- Symptom Management
- Correct the correctable
- Non-drug treatment
- Symptomatic drug treatment





PALLIATIVE PERFORMANCE SCALE

**Palliative Performance Scale (PPSv2)
version 2**

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity <i>with</i> Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Used with permission Victoria Hospice Society, 2006



MONITORING

- Review, review, review
- Team working
- Involve family/community
- Opportunity to ask questions
- Assess value of each intervention
- Risk/benefits



WHAT ANTI-EMETIC DO YOU USE MOST OFTEN?

- Sumita, 48 year- old female with carcinoma colon
presents with persistent vomiting



SUMITA'S COMPLAINTS - YOUR PLAN ?

- Reports colicky abdominal pain
- Distension of abdomen
- Bilious vomiting
- Bowels not opened 1 week
- Received chemotherapy 3 days ago





SUMITA'S COMPLAINTS - YOUR PLAN?

- Received chemotherapy 3 days ago



SUMITA'S COMPLAINTS - YOUR PLAN?

History of severe headache and weakness of right half of the body



SUMITA'S COMPLAINTS - YOUR PLAN?

- Is scheduled for 3rd cycle of chemotherapy
- She had severe CINV last 2 times
- This time she starts vomiting before she reaches the hospital



SUMITA'S COMPLAINTS - YOUR PLAN?

- Reports dizziness and vertigo
- Head movement causes vomiting



SUMITA'S COMPLAINTS - YOUR PLAN?

- She has been prescribed Tramadol 100 mg QID for pain



SUMITA'S COMPLAINTS - YOUR PLAN?

- Increased pain over right upper abdomen
- Early satiety
- Continuous pain
- Increased on deep inspiration and loss of appetite
- Feeling of fullness



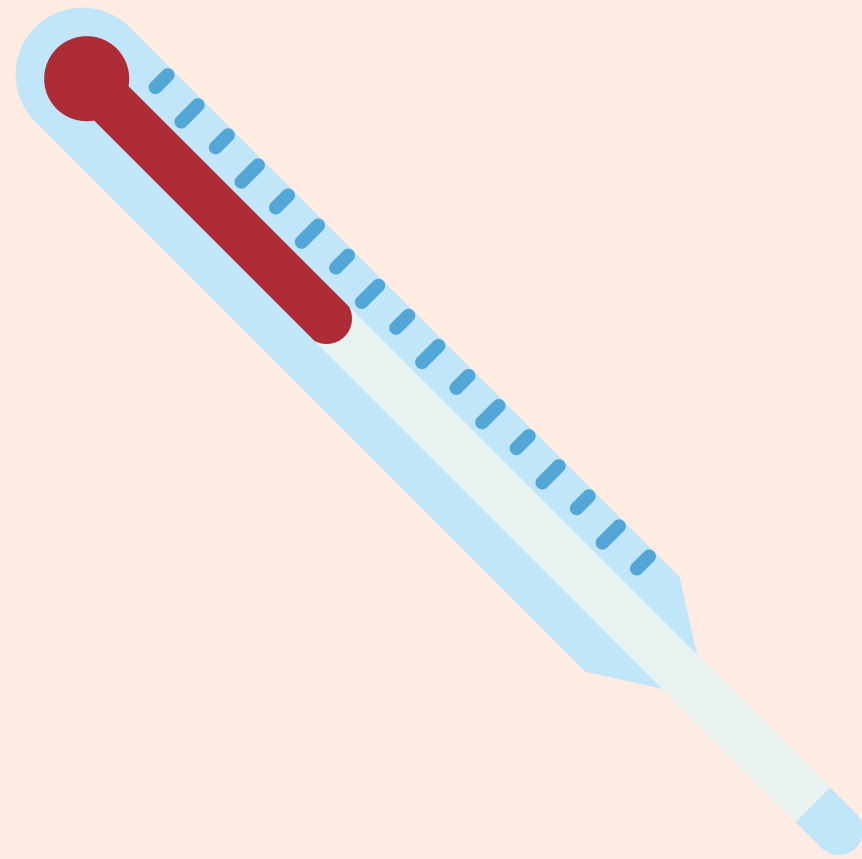
SUMITA'S COMPLAINTS - YOUR PLAN?

- History of increasing joint pain
- Is on NSAIDs for a long time
- Symptoms of epigastric pain



SUMITA'S COMPLAINTS - YOUR PLAN?

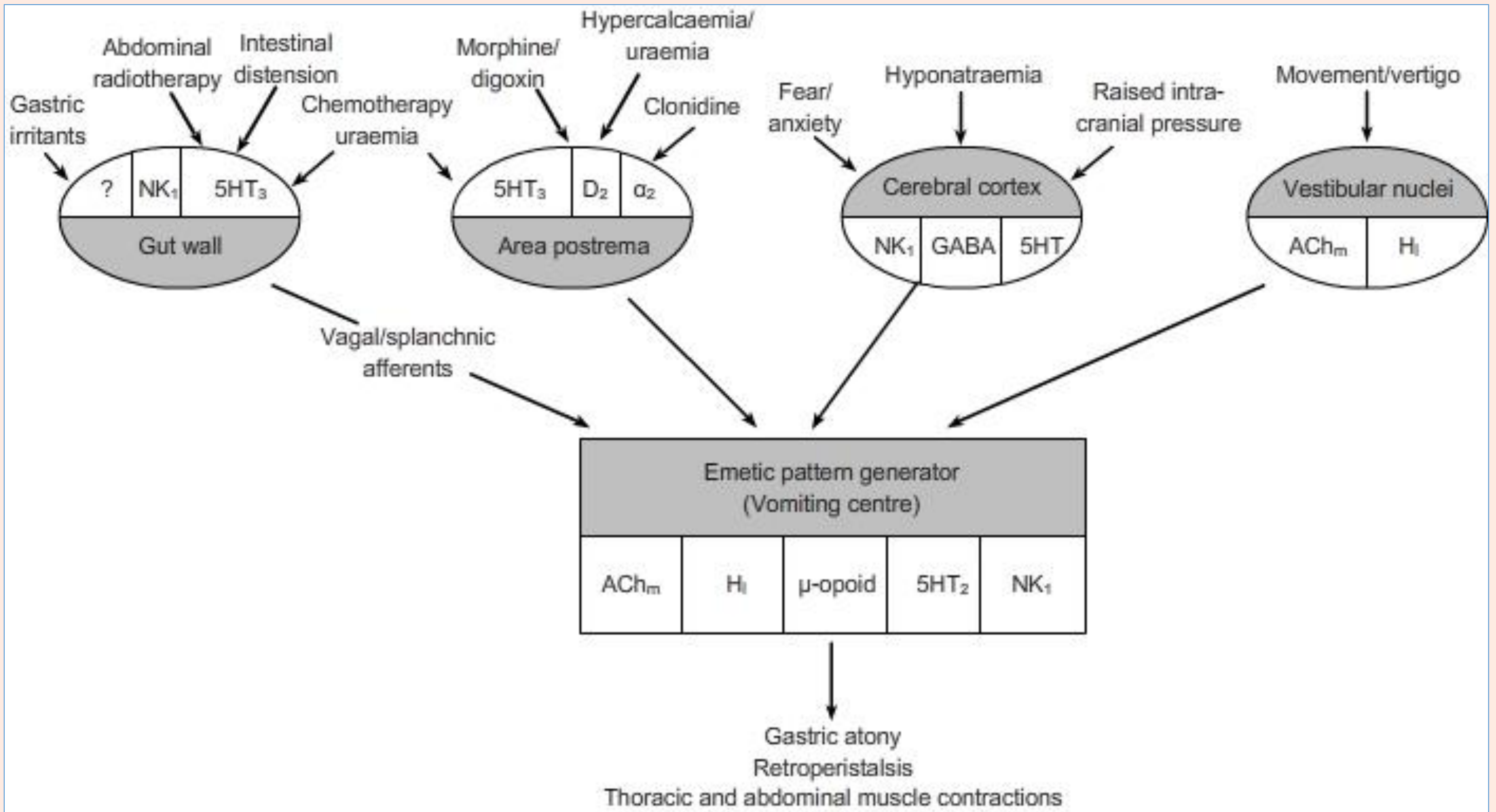
History of fever and diarrhea



SUMITA'S COMPLAINTS - YOUR PLAN?

- Sumita's disease progressed, she now has liver metastases and a colostomy.
- She is comfortable most of the day but has severe nausea and occasional vomiting when
 - The colostomy is cleaned
 - Her daughter cooks dal (uses heeng) and meat

EMESIS PATHWAY





10 M (M1 to M3)

Metastasis	<u>Cerebral</u> Raised ICT - CTZ <u>Liver</u> Toxin build up	CTZ Cerebral	Steroids, Mannitol
Meningeal	Leptomeningeal disease -raised ICT	CTZ Cerebral	Steroids
Medication	Opioids	CTZ, Vestibular , GI	Metoclopramide (D) Haloperidol (D) Promethazine (Ach)
	Chemotherapy	CTZ , GI	Ondansetron (5HT3) Dexamethasone
	NSAIDs	CTZ, GI	Omeprazole Ondansetron



10 M (M4 to M6)

Movement	Vestibular stimulation – Usually Morphine associated		Promethazine
Mentation	Cortical activity – Anxiety		Lorazepam (GABA)
Mechanical	Luminal	Constipation	Manage constipation
	Wall	Tumor ,stricture	Manage bowel obstruction
	Extra luminal	Peritoneal deposits	



Classification of Anti-Emetics - Central Nervous System

Vomiting centre	Antimuscuranic Antihistaminic 5HT ₂ -receptor antagonist NK ₁ -receptor antagonist	Hyoscine Cyclizine Levomepromazine, Olanzapine Aprepitant
Area postrema (chemoreceptor trigger zone)	D ₂ -receptor antagonist 5HT ₃ -receptor antagonist NK ₁ -receptor antagonist	Haloperidol, Metoclopramide, Domperidone Granisetron, Ondansetron Aprepitant
Cerebral cortex	Benzodiazepine Cannabinoid Corticosteroid NK ₁ -receptor antagonist	Lorazepam Nabilone Dexamethasone Aprepitant

10 M (M7 to M10)

Metabolic	Hypercalcemia/Hyponatremia Liver/Renal failure - CTZ		Dexamethasone, correction Ondansetron
Motility	Opioids, Ileus and other medications		Metoclopramide Bisacodyl
Mucosal	NSAIDs, APD, GERD – GI		Antacids, PPIs
Microbes	Oral cavity	Candida, infected mouth ulcers	Topical antifungal, gargles
	GI	Herpes, CMV, H.P	Antibiotics, Antiviral
	Systemic sepsis	CTZ	Antibiotics



Classification of Anti-Emetics - Gastrointestinal System

Prokinetics	5HT ₄ -receptor agonist D ₂ -receptor antagonist Motilin receptor agonist	Metoclopramide Metoclopramide, Domperidone Erythromycin
Antisecretory	Antimuscuranic Somatostatin analogue	Hyoscine Octreotide, Lanreotide
Vagal 5HT ₃ -receptor blockade	5HT ₃ -receptor antagonist NK ₁ -receptor antagonist	Granisetron, Ondansetron Aprepitant
Anti-inflammatory	Corticosteroid	Dexamethasone

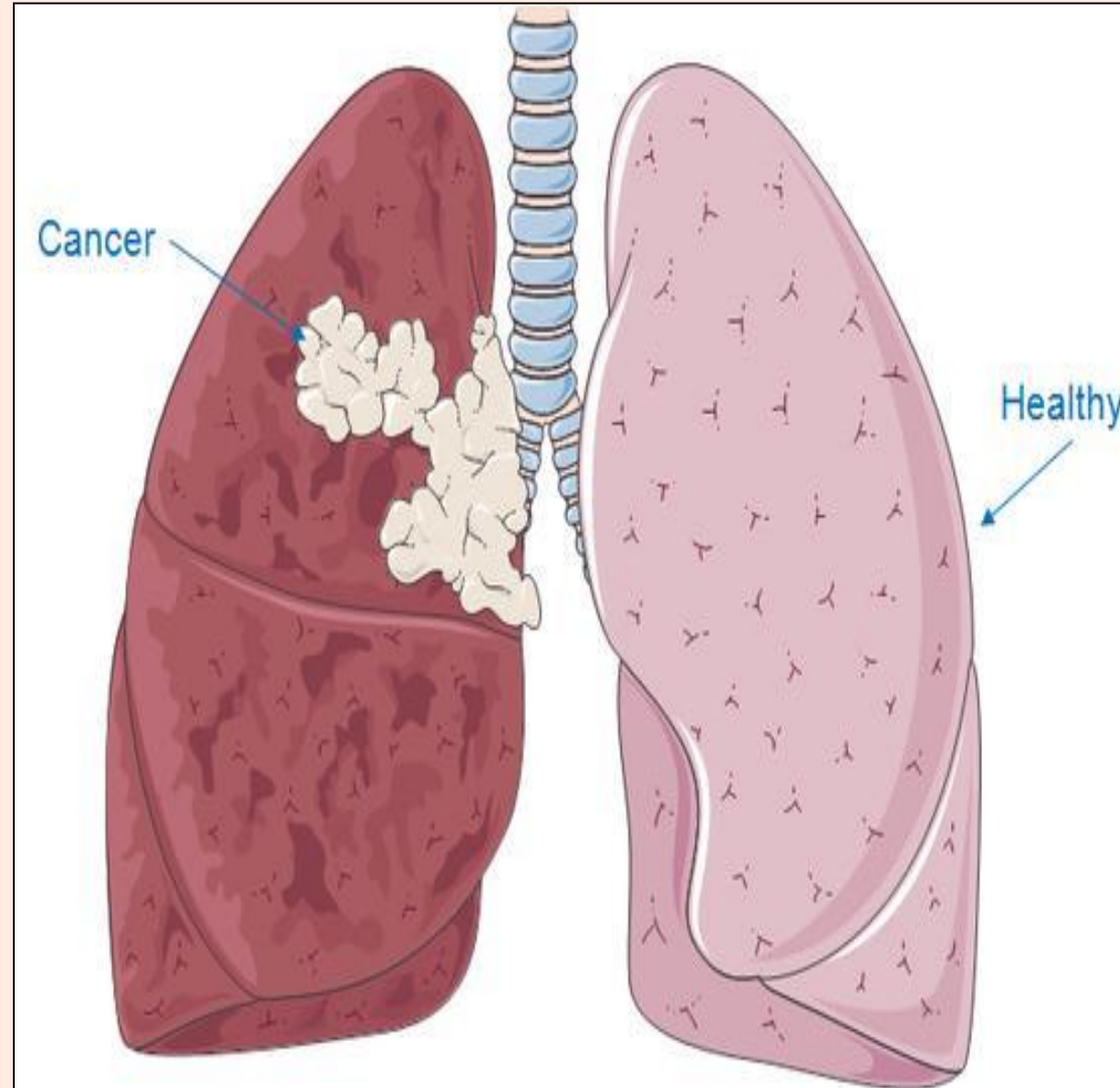
DYSPNOEA: IN PALLIATIVE CARE

- Extremely common
- Ca Lung, breast, prostate, colo-rectal, renal
- Especially in terminal stages
- Sinister significance
- Associated exhaustion, and anxiety
- Lack of independence
- Respiration Rate can be 30 to 60 /min



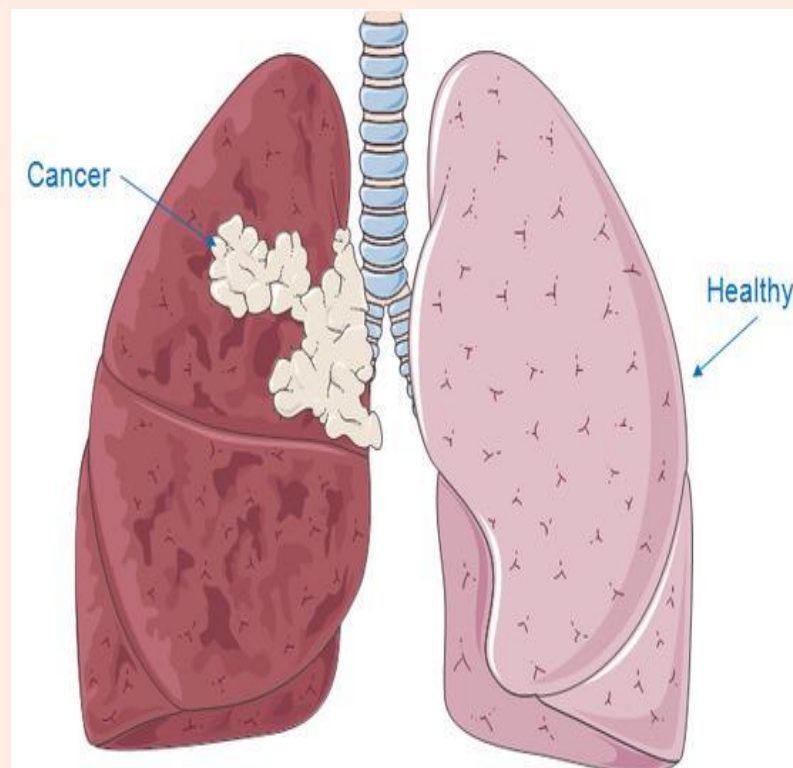


DYSPNOEA



DYSPNOEA: IN CANCER PATIENTS

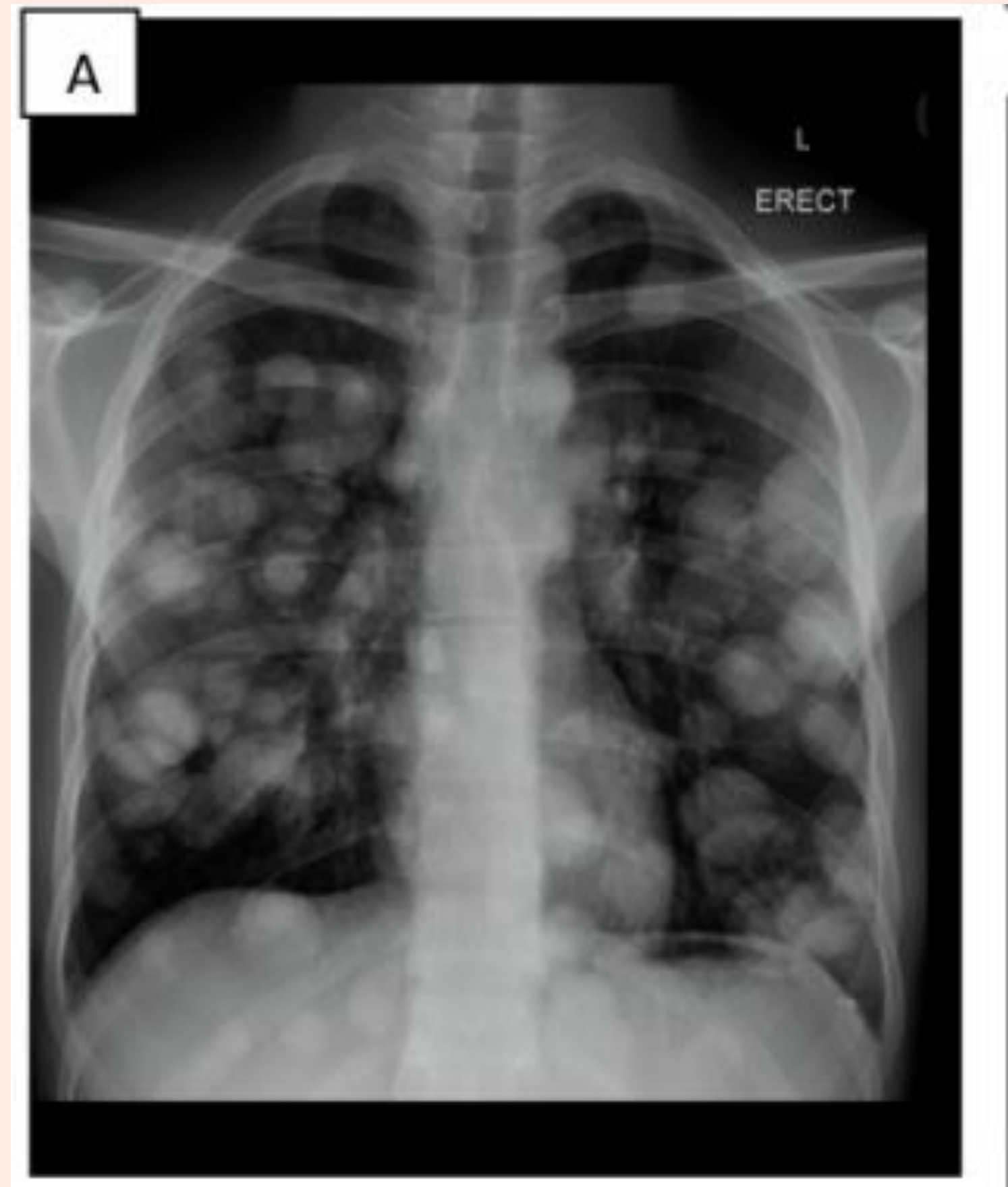
Lung Cancer





DYSPNOEA: IN CANCER

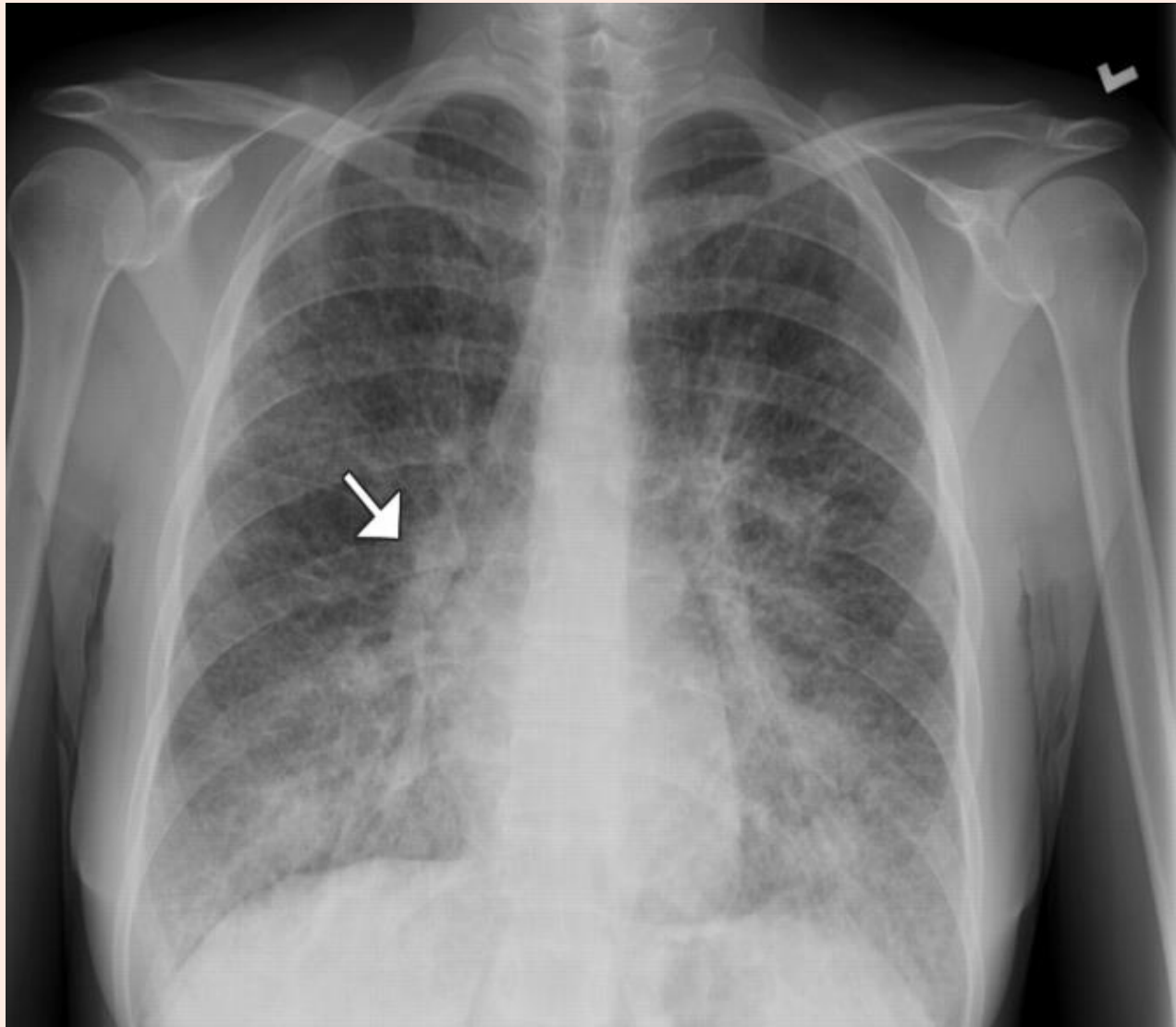
Pulmonary Metastases





DYSPNOEA

Lymphangitis



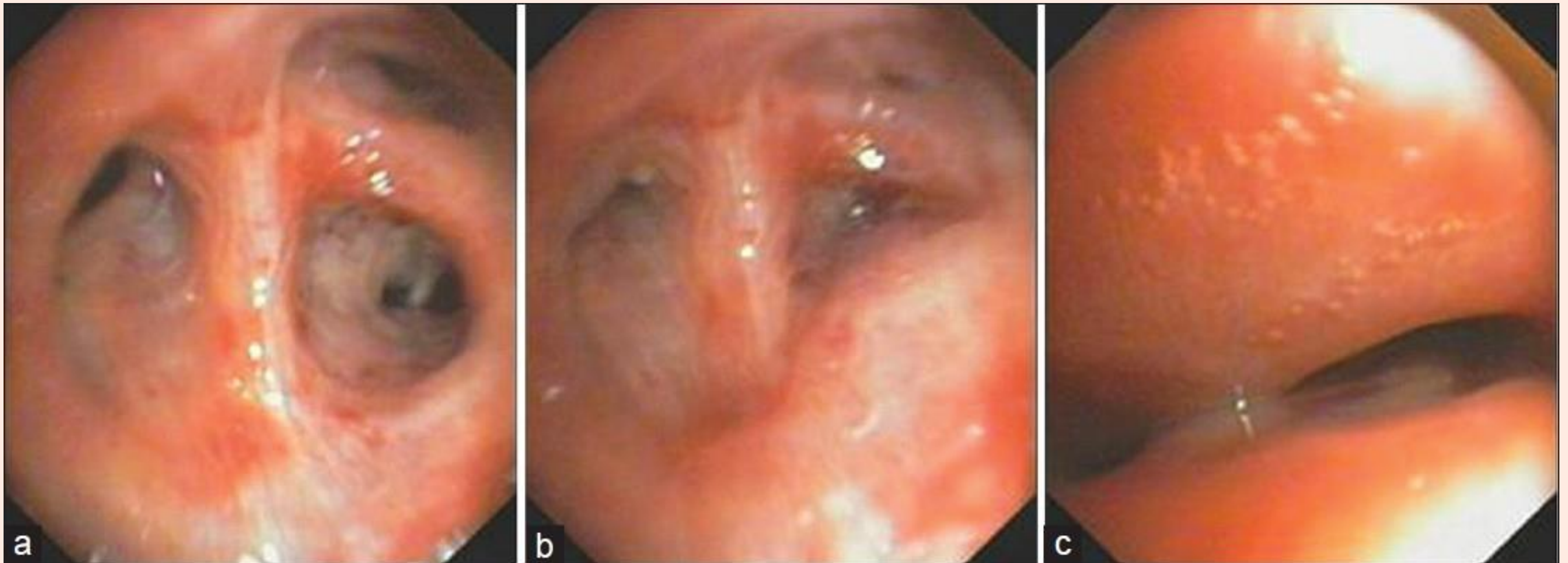
DYSPNOEA: IN CANCER PATIENTS

Fibrosis



DYSPNOEA: IN CANCER PATIENTS

- Airway obstruction
 - tumour / collapse / TOF



DYSPNOEA: CARDIAC CAUSES

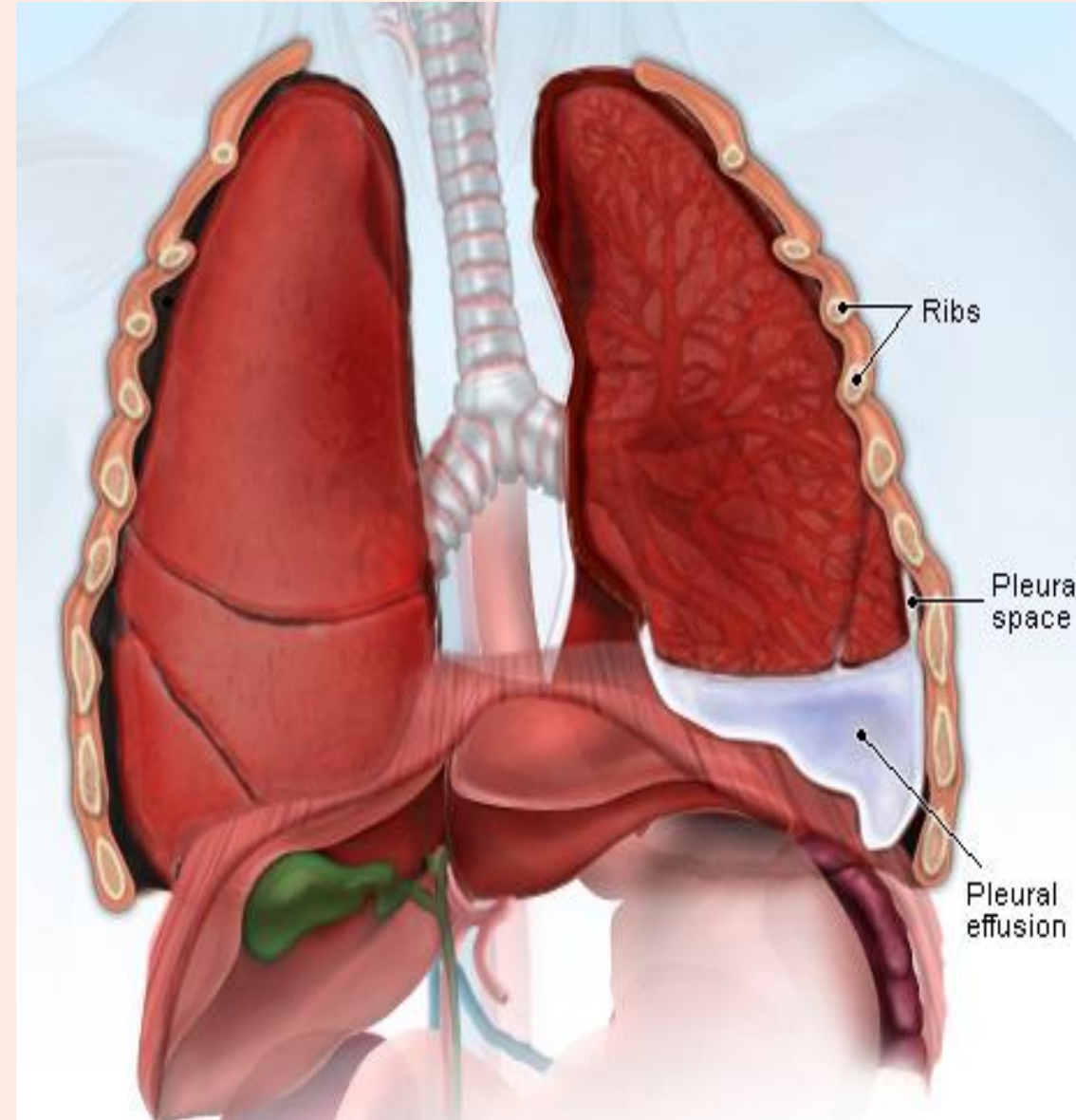
- Cardiac
 - Pericardial effusion
 - Arrhythmias





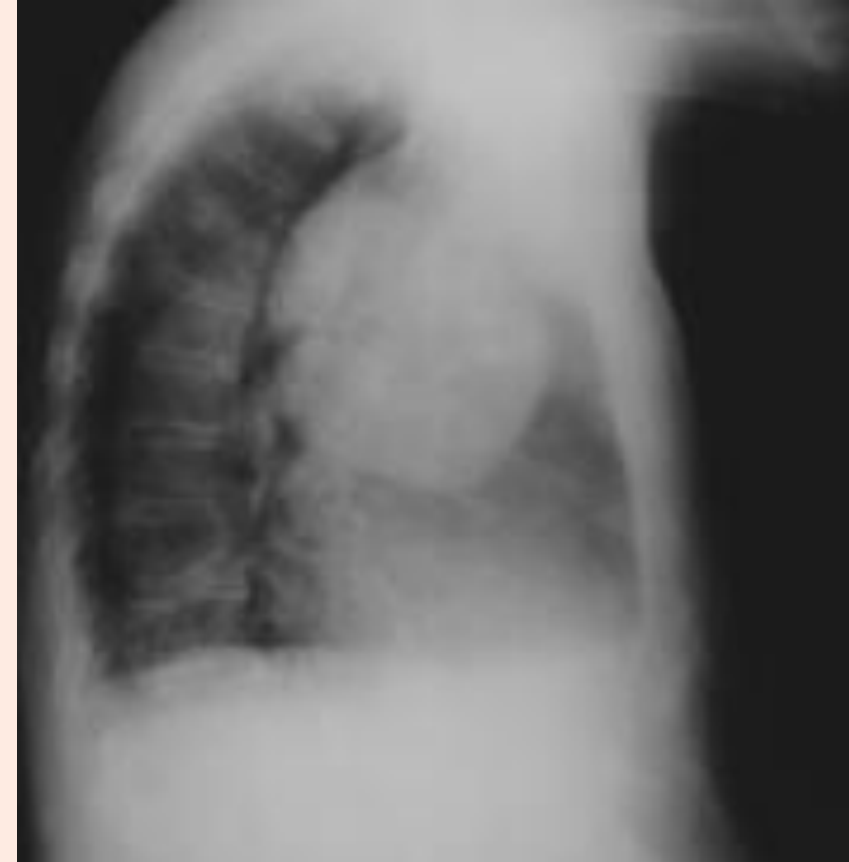
DYSPNOEA

- Pleural
 - Effusion
 - Pneumo-thorax



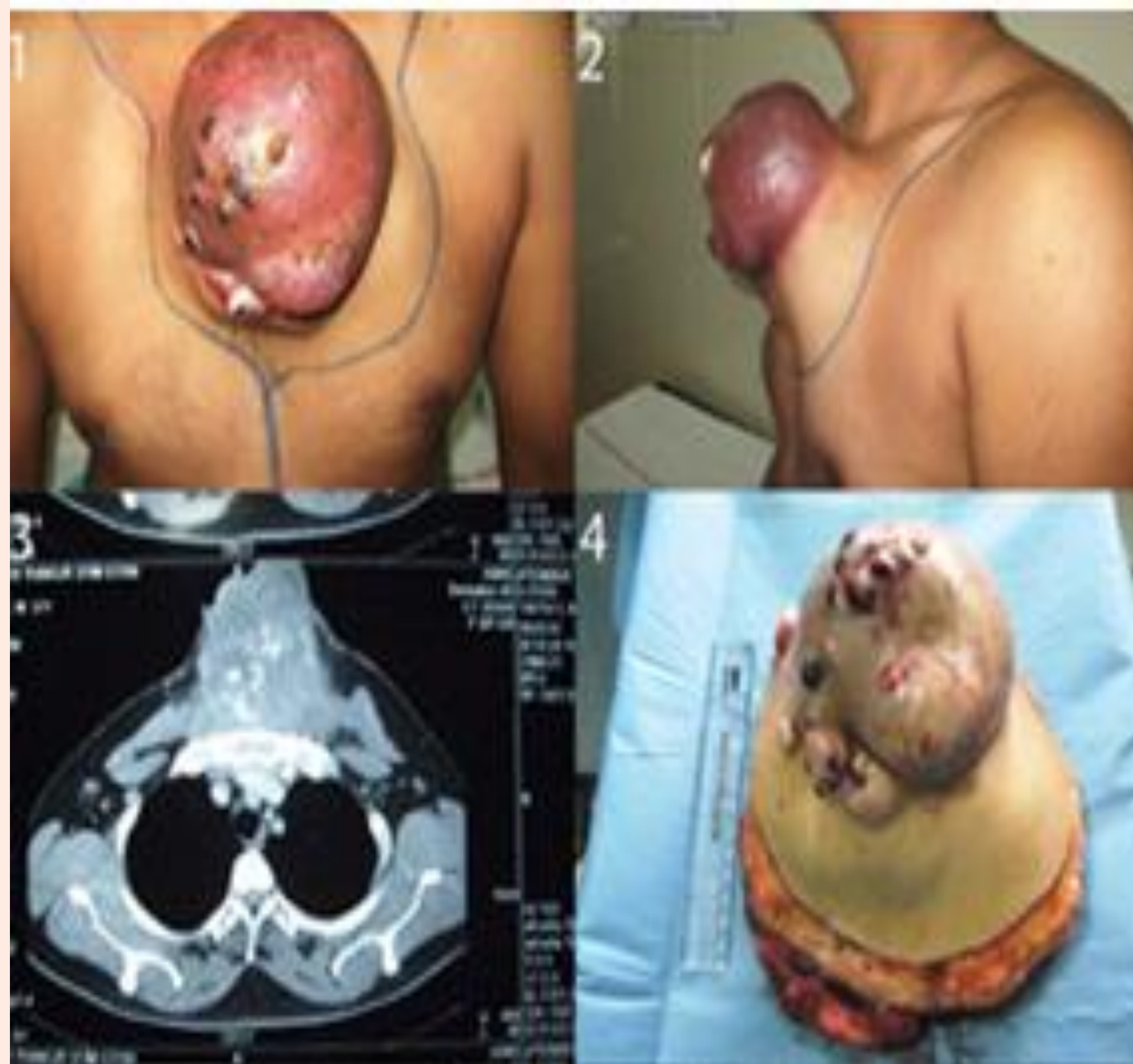
DYSPNOEA: IN CANCER PATIENTS

- Mediastinum
 - Tumour
 - Phrenic nerve palsy
 - SVC obstruction



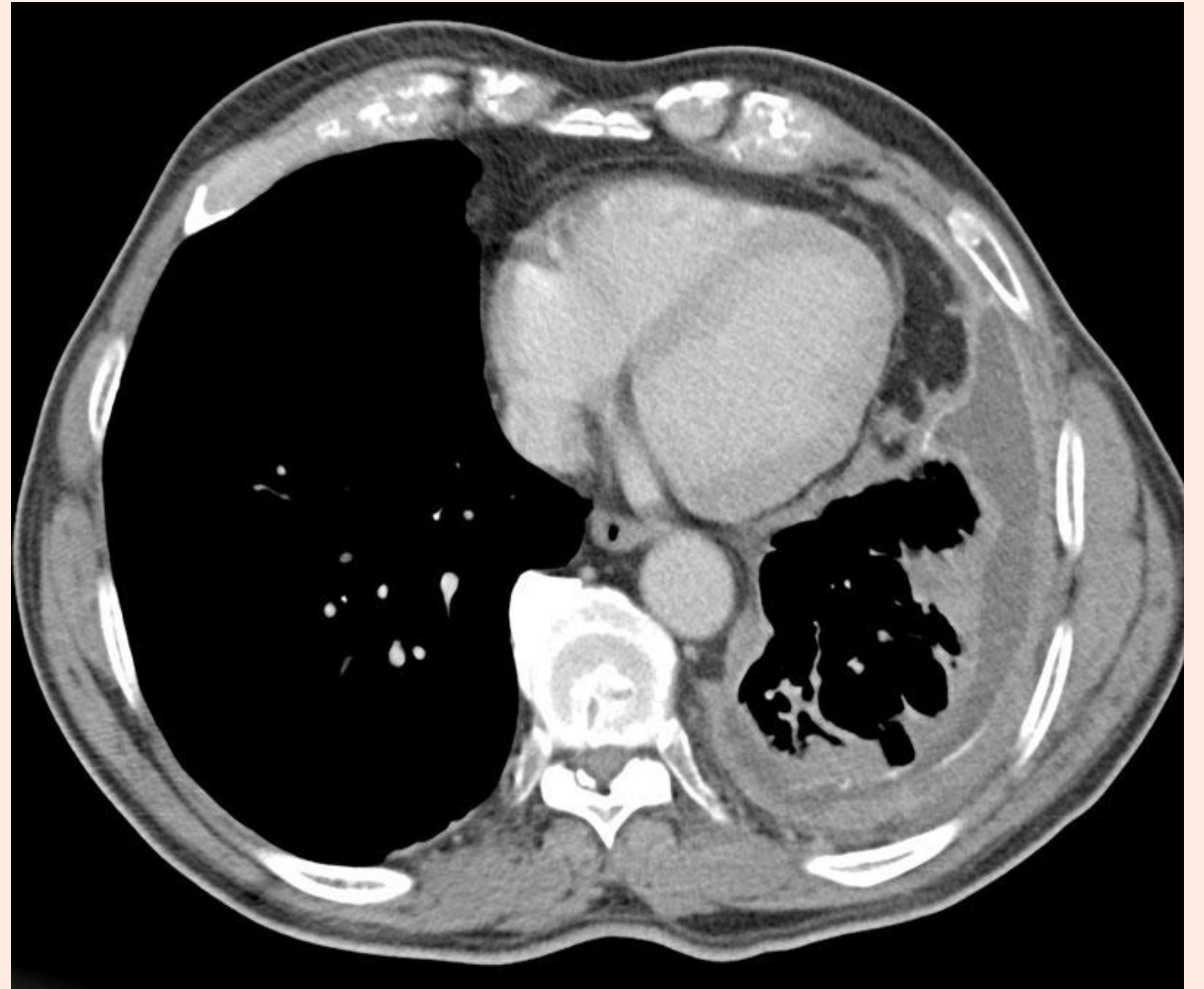


THORACIC CAGE



DYSPNOEA: IN CANCER PATIENTS

- Thoracic cage
 - Chest wall
 - Mesothelioma



DYSPNOEA: IN CANCER PATIENTS

- Thoracic cage
- Chest wall
- Mesothelioma
- Cancer en-cuirasse
- Muscle fatigue





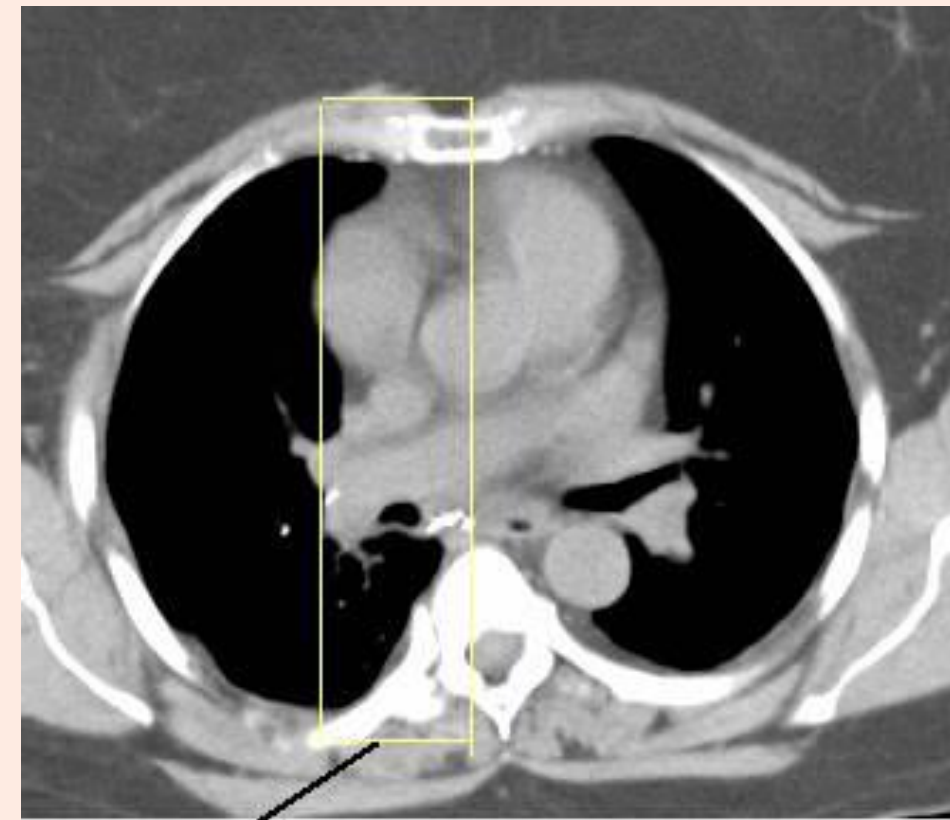
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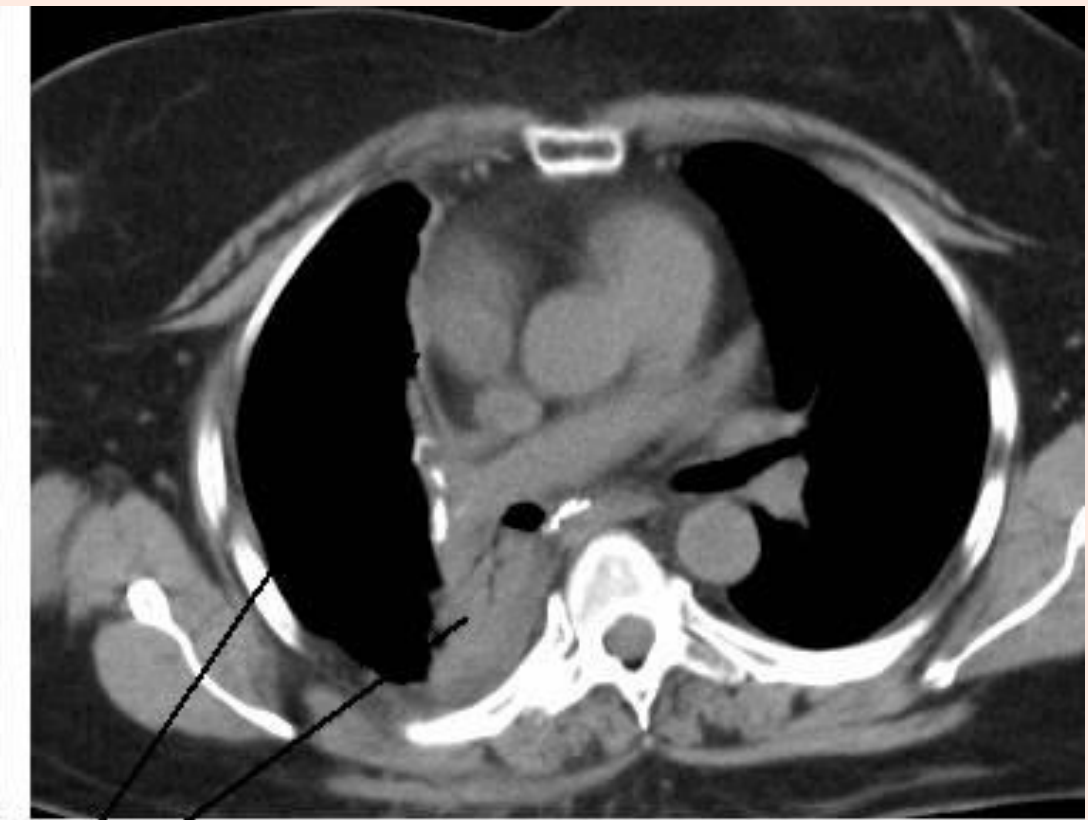


DYSPNOEA: IN CANCER

- Tumour
- Treatments
 - Radiotherapy
 - Chemotherapy
 - Pneumonitis
 - Cardio-myopathy
 - Pneumo-nectomy
- General debility
- Anaemia



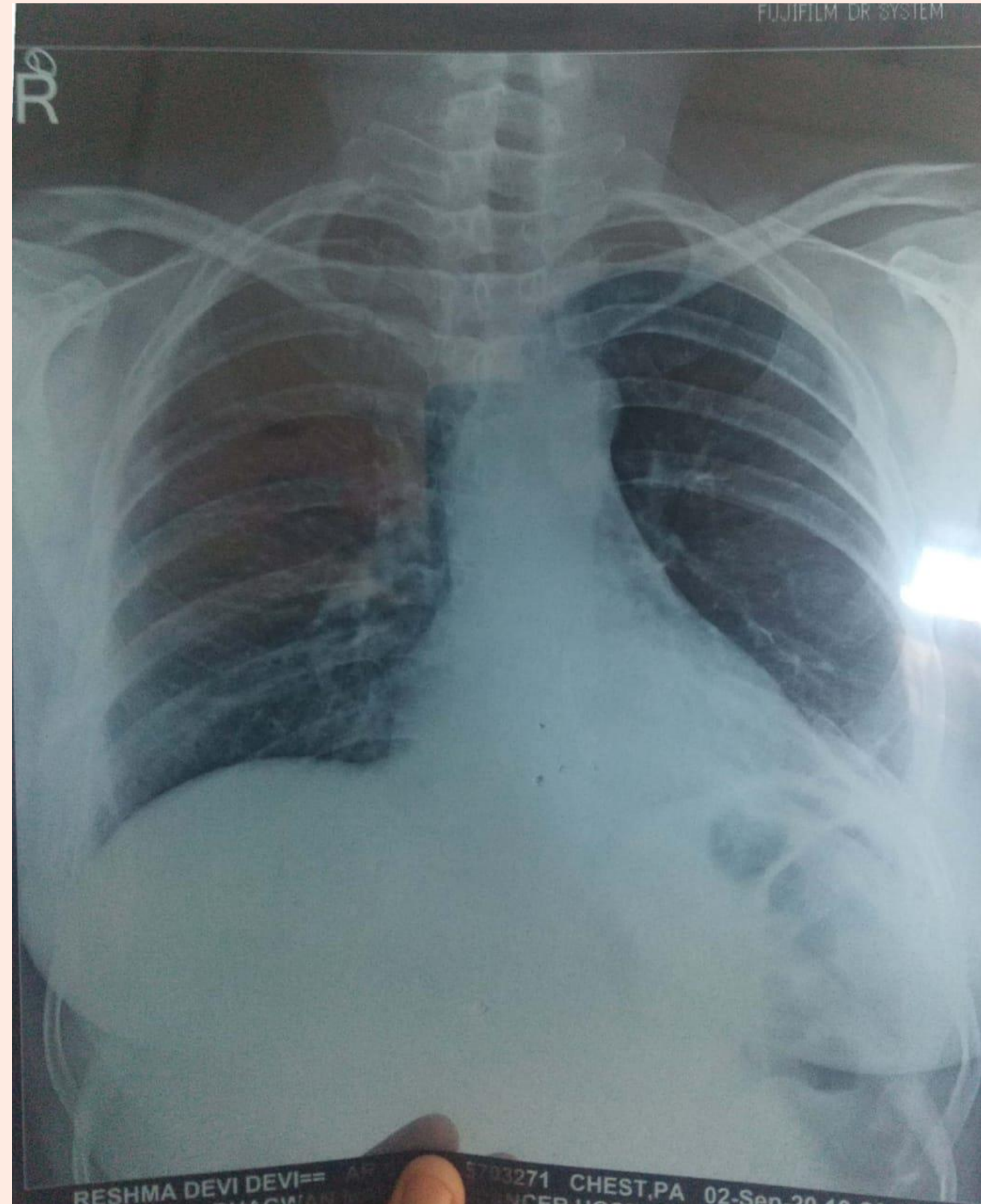
Radiation Field



Radiation Fibrosis
8 months later



DYSPPNEA - CAUSE





- Bronchial asthma
- SVC obstruction
- Pulmonary embolism
- Lymphangitis carcinomaosis
- Resp. muscle weakness
- Ascites
- Anaemia
- Metabolic acidosis
- Panic attacks
- Early ARDS

**NORMAL X-RAY,
SEVERE
BREATHLESSNESS**

DYSPNOEA: MEASUREMENT

No standard format

- Verbal categorical scale
- Mild - Moderate - Severe
- VAS
- Borg scale

MRC DYSPNOEA SCALE	
Grade	Degree of breathlessness related to activities
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying or walking up a slight hill
3	Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4	Stops for breath after walking about 100m or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when dressing or undressing



DYSPNOEA: EVALUATION, EXPLANATIONS

- CXR
- Objective tests (eg peak flow / FEV) are unhelpful
- Do not add to the distress / financial burden
- PFTs NOT useful (eg blood gases / angio etc)
- VQ / CT PA only of use if high suspicion of PE
- Discuss options with Patient / family
- Emphasis on “Quality” not longevity

CORRECT THE CORRECTABLE ?

- | | |
|--|----------------------------------|
| 1. Respiratory infections | 6. Pleural, Pericardial effusion |
| 2. COPD / Bronchial asthma | 7. Ascites |
| 3. Hypoxia | 8. Anaemia |
| 4. Superior <u>venacaval</u> obstruction | 9. Cardiac failure |
| 5. Lymphangitis Carcinomatosis | 10. Pulmonary embolism |





NON PHARMACOLOGICAL INTERVENTIONS

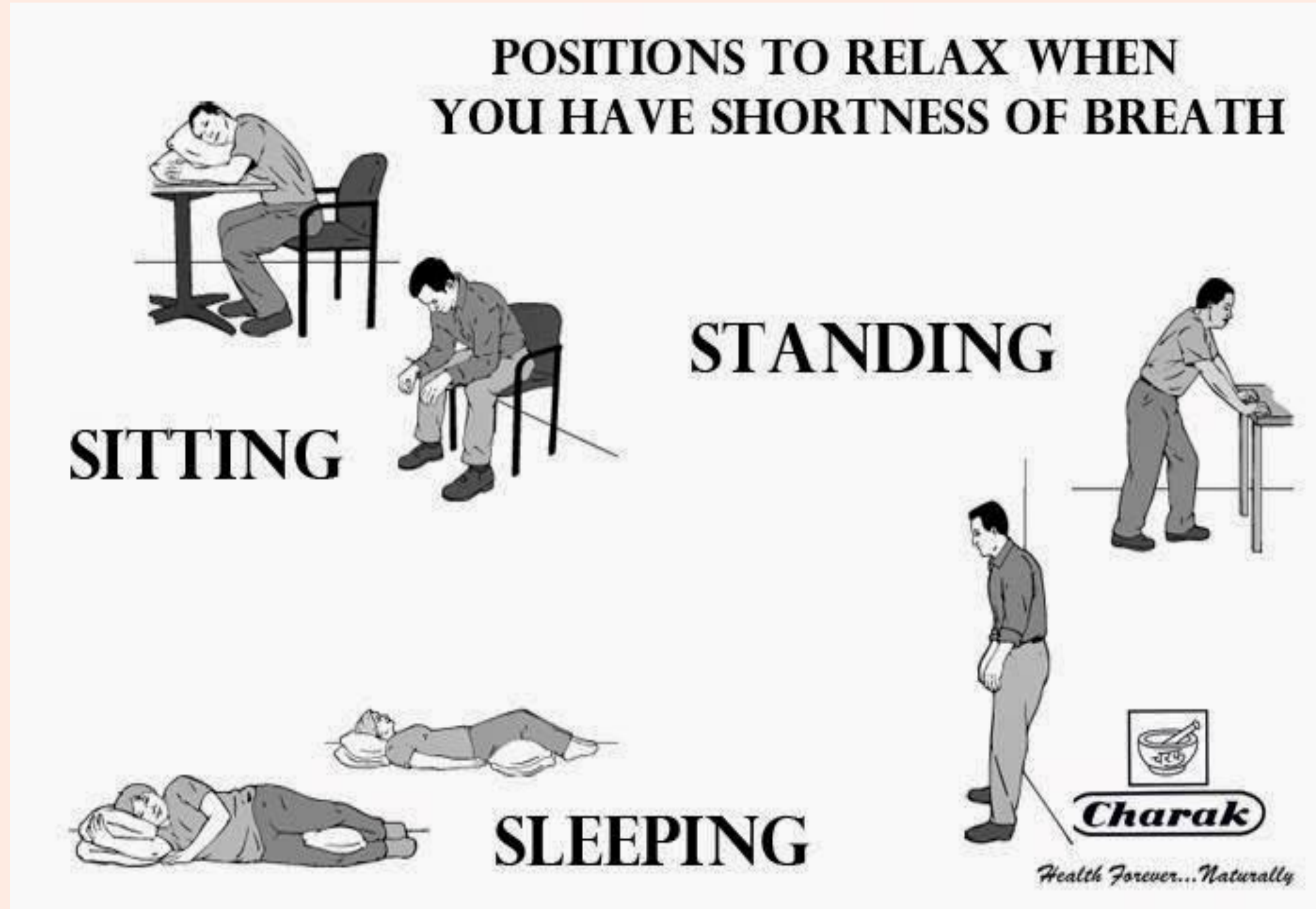


FIND THE MOST COMFORTABLE POSITION FOR THE PATIENT

- Propped up
- Cardiac table
- Pillows
- Pursed lip breathing



DYSPNOEA: NON-DRUG MEASURES

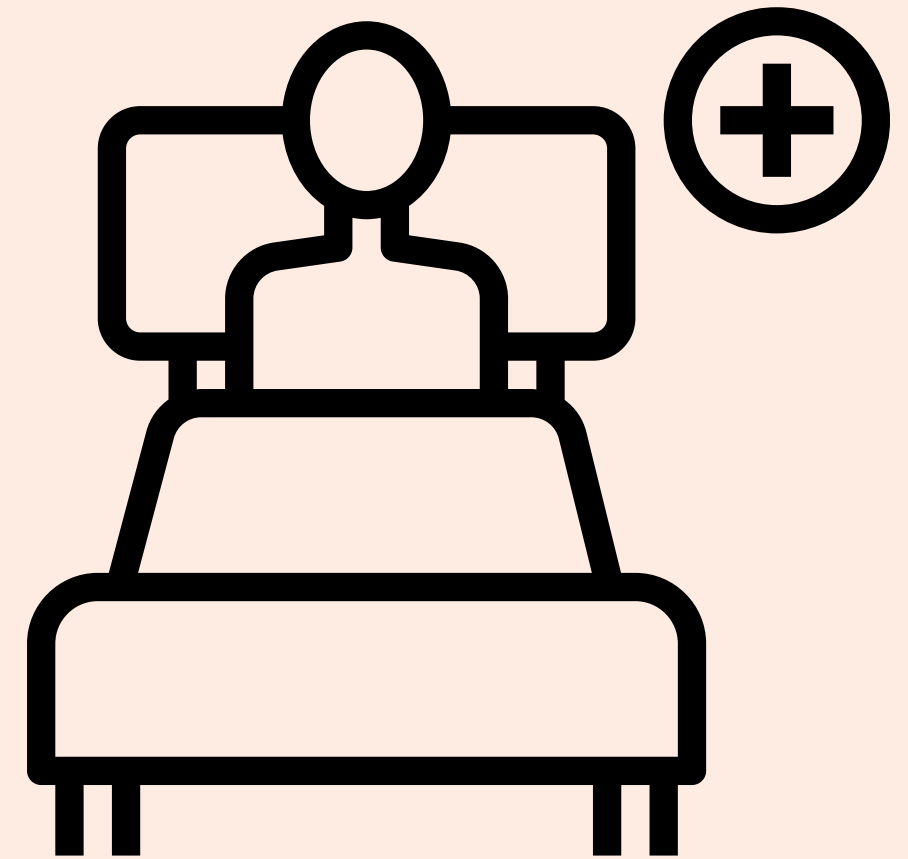


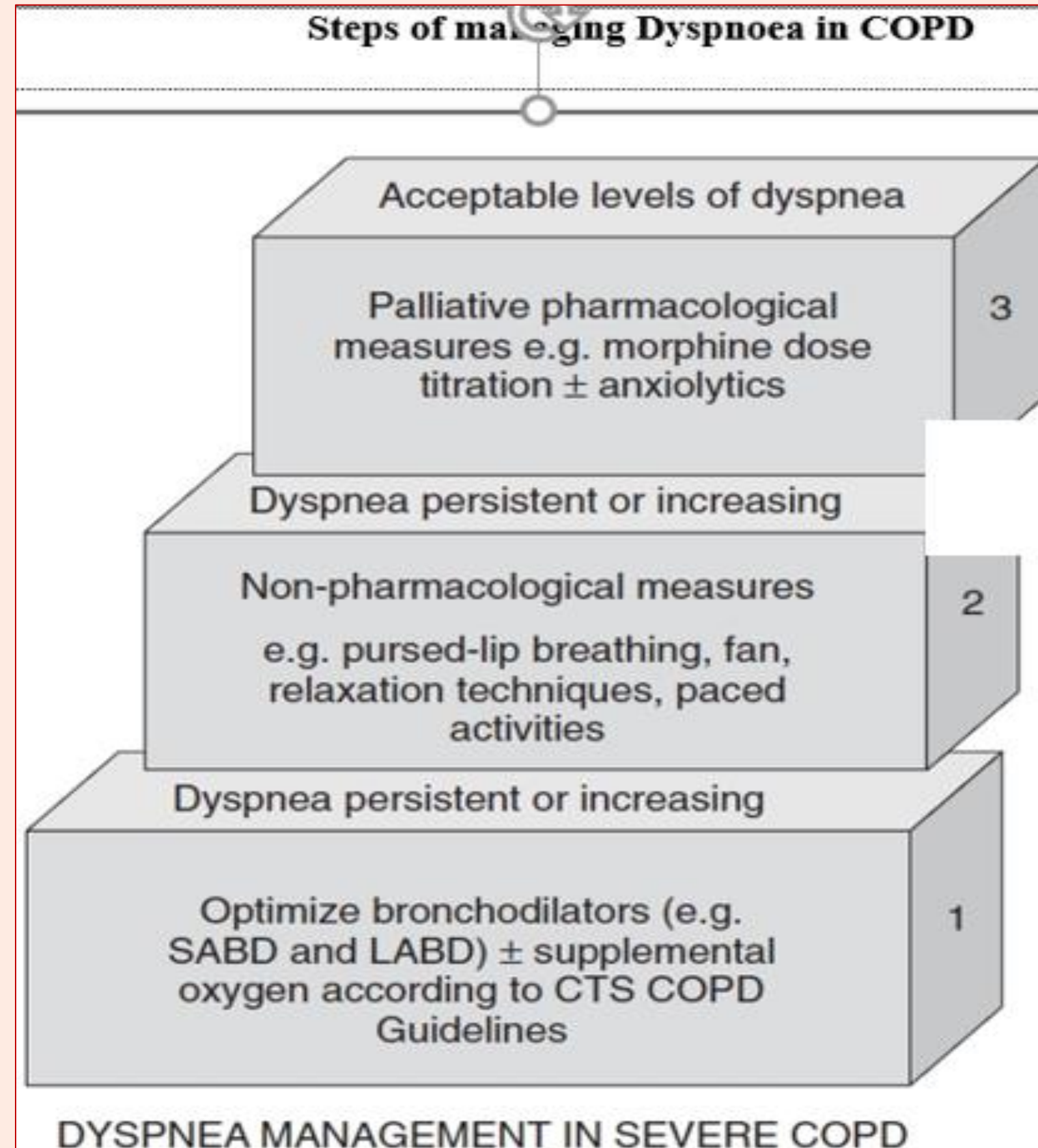
NON-PHARMACOLOGICAL INTERVENTIONS

- An electric fan/ cool breeze may provide symptomatic relief
- Open window, keep line of sight to outside (if possible)
- Reduce room temperature, if possible
- Presence of “calm” family
- Limit the number of people in the room
- Eliminate environmental irritants like smoke
- Loose clothes

DYSPNOEA: NON-DRUG MEASURES

- Calm, positive approach
- Breathing exercises implemented early
- Behavioral approaches—relaxation, distraction, hypnosis
- Counseling, coping skills
- Complementary therapies
- Physiotherapy input, massage
- Occupational therapist: equipment for energy conservation
- Adaptation of way of life, pacing





DYSPNOEA: OPIOIDS

- Morphine acts on medullary respiratory centre
- Makes it less sensitive to CO₂ accumulation
- Reduces the excess ventilatory drive/ response to hypoxia and hypercapnia
- Slows breathing, making it more efficient
- Reduces sensation of breathlessness



- Trial of Morphine fully justified
- If opioid naive:
 - 2.5mg every 4 hrs
 - Can be escalated
 - >5 mg /4hrly unlikely to produce further benefit
- If on opioids already
 - give 50 to 100% of current dose
- Opioids DO NOT cause respiratory depression in cancer patients needing pain control!



USE OF OXYGEN

- May relieve mild dyspnea in some situations
- Rarely completely effective for severe dyspnea
- Can be helpful if hypoxia / cyanosis
- Sudden panic / hyperventilation
- Possibly in COPD / lymphangitis
- Usually not needed to relieve the dyspnea of a dying patient



OXYGEN THERAPY- CONTROVERSY

- Saturation may not be helpful to measure dyspnea
- Expensive, especially in the home setting
- Symbolizes medical care – thus sometimes requested by families
- Placebo
- Social (barrier)
- Logistics may not be readily available





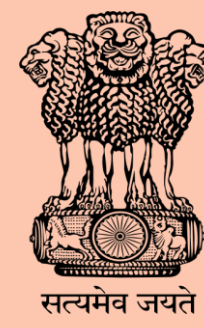
DYSPNOEA



SYMPTOM MANAGEMENT

- Not always possible to relieve a symptom completely
- Often a case of helping a patient move from being overwhelmed by a symptom to exercising some control over it





Thank You

