Palliative medicine: medical and psychological aspects

Gwenllian Davies

Simon Noble

Abstract

Palliative medicine/palliative care is a speciality aimed at symptom control in patients with life-limiting illnesses. Palliative medicine no longer focuses on care of the dying only but is an integral part of the management of patients with a life-limiting illness. It approaches symptom control in a holistic manner addressing a patient's physical, psychological, social and spiritual needs. This article aims to give an overview of the principles of palliative medicine and guidance on management of particular, frequently seen symptoms, emergencies and end of life care.

Keywords End of life care; palliative medicine; symptom control

Introduction

Palliative medicine as a speciality was first recognized by the Royal College of Physicians in 1987. It has evolved from the hospice movement and a desire to improve symptom control for patients with cancer, but has since developed to encompass other life-limiting illnesses. All aspects of this article are further discussed in the palliative medicine edition of our sister journal '*Medicine*'.

WHO definition of palliative care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:

- Provides relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten or postpone death.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Offers a support system to help the family cope during the patient's illness and in their own bereavement.
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated.
- Will enhance quality of life, and may also positively influence the course of illness.
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.[1]

Approach to management:

Physical	Spiritual
Psychological	Social

Every patient and each of their symptoms should be approached with the above structure in mind, taking into account the four different causes/contributory factors to the symptom. For example with pain:

- physical – pain caused by tumour compression of a nerve
- psychological – fears about the pain escalating
- spiritual – why has this happened to me?
- social – pain affecting function and therefore loss of role in work/family.

In order to manage different symptoms a multidisciplinary team (MDT) approach must be taken which includes:

- doctors i.e. (particularly in cancer management):
  - surgeons
  - oncologists
  - palliative medicine physicians
  - GPs
- specialist nurses in the above and district nurses
- physiotherapists
- occupational therapists
- social workers
- councillors (for patients and families).

Palliative medicine is no longer confined to a hospice setting and as the members of the MDT shows it is now an integral part of all medical care. Palliative care can and is delivered in a hospital and community setting. Within the community it can be delivered in a patient's home as well as in nursing homes.

Physical symptoms

Pain

This is a relatively common symptom but is not experienced by every patient.[2] As discussed above it should be managed considering the four different categories of contributory/causative factors. We can then break down the management into pharmacological and non-pharmacological.

Pharmacological management should be carried out based on the WHO pain ladder[3] (Figure 1). In choosing drugs to manage pain it is important to consider the physical cause of the pain. For nociceptive or 'normal' pain (caused by tissue injury), the ladder can be followed step by step relying mostly on the non-opioid and opioid analgesics. Non-opioid analgesics include paracetamol, NSAIDs and entenox. However, for neuropathic pain (pain caused

Gwenllian Davies *MBChB (Hons) MRCP is a Registrar in Palliative Medicine at Velindre Cancer Centre, Cardiff, UK. Conflicts of interest: none declared.*

Simon Noble *MBBS FRCP PGCE DipPalMed is a Clinical Senior Lecturer and Honorary Consultant in Palliative Medicine, the Department of Palliative Medicine, Royal Gwent Hospital, Newport, Wales, UK. Conflicts of interest: none declared.*

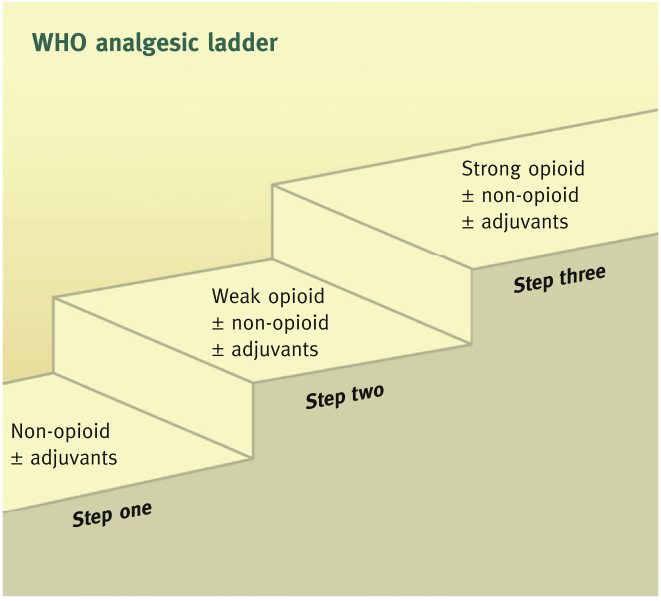

Figure 1

by damage to nerves by compression or injury) adjuvant analgesics such as tricyclic antidepressants or anti-epileptics should be considered earlier. For pain caused by bony metastasis a bisphosphonate should be considered as an adjuvant.

It is important to appreciate the equivalent strengths of opioids when prescribing. The potency of commonly prescribed 'weak' opioids may have their strength underestimated, leading to untoward side effects in opioid naïve patients. Relative potencies of some common analgesics are given in Table 1.

As well as choosing the type of analgesia to be used, the duration of action of analgesia required should be considered. For titration and incident/breakthrough pain a short-acting analgesic is ideal. Breakthrough pain is defined as 'a transitory exacerbation, or flare of moderate to severe pain that occurs on a background of otherwise stable persistent pain in a patient receiving chronic opioid therapy'.[4] Incident pain refers to pain brought on by a voluntary or involuntary action such as walking or sneezing. For stable, constant pain a long-acting analgesic would be chosen. Modes of delivery should also be considered; the first choice of route of delivery as with most other specialities of medicine is oral, but if this is not possible then the subcutaneous/topical/buccal/transdermal routes should be considered (each have their own merits).

Non-pharmacological management of pain includes use of the full MDT. Treatments to be considered here are:

- positioning
- heatpacks
- TENS machines (transcutaneous electrical nerve stimulation)
- complementary therapy (i.e. acupuncture)
- radiotherapy
- aids (equipment to aid mobility and activities of daily living)
- psychological support including counselling(it is important not to overlook this, because if psychological contributions to pain are not addressed then it can become impossible to control pain).

Common analgesics

OPIOID	Oral morphine equivalent
Cocodamol 30/500 2 QDS	24 mg
Tramadol 100 mg QDS	50—80 mg
Oxycodone 15 mg	30 mg

Table 1

Nausea and vomiting

As with pain it is important to consider the cause of the nausea and vomiting because different causes will infer different management. For partial obstructive symptoms (e.g. hepatomegaly causing pressure on the stomach) a prokinetic such as metoclopramide should be considered and can be given orally or subcutaneously.

Other causes to consider would be electrolyte abnormalities such as hypercalcaemia and uraemia. It would be reasonable to try and correct these while treating the underlying symptoms with an anti-emetic such as haloperidol. Intracranial metastasis may cause nausea and vomiting through raised intracranial pressure and as above treatment of the raised intracranial pressure should be started alongside that for nausea and vomiting.

For nausea and vomiting, a change in the route of delivery of medication may need to be considered earlier than for most other symptoms due to malabsorption. In doing this other medications being taken, not only the anti-emetic, should be considered for conversion to the subcutaneous route. It is also of importance to pre-empt these symptoms as they may often be associated with starting opioids or chemotherapy. If the patients are prepared for these symptoms and are co-prescribed an anti-emetic the distress may be reduced (Table 2).

Constipation

This is often seen as a consequence of prescribing opioid analgesics and therefore an easy way to try and avoid this is through co-prescribing of a laxative (Table 3). Other contributory causes would be decreased mobility and decreased fluid intake.

Emergencies in palliative medicine

Metastatic spinal cord compression

Signs and symptoms of this are back pain, leg weakness, and bladder and bowel disturbance. The management of this is outlined by NICE guidelines[5] and some of the recommendations are that an MRI of the whole spine should be carried out within 24 hours of suggestive signs and symptoms. Definitive treatment (spinal surgery or radiotherapy) should be started before any neurological deterioration and ideally within 24 hours of

Prescribing for nausea and vomiting

Cause of nausea	Suggested anti-emetic
Gastrostasis	Metoclopramide (caution in obstruction)
Central	Cyclizine/haloperidol

Table 2