Palliative Pearls of Wisdom

A summary of useful information for caring for palliative patient at home. Gained from my recent PEPA placement

Nausea and Vomitting

- There several ‘types’ or causes of N and V:
- Reflux – gastric irritation. Contributes to pain, radiates up the eosophagus
- GIT – provoked by eating. Gastric/oesophageal cancers
- Central nausea – chemo, triggers in brain, smells, food prep
- GBM/Brain cancers – raised intracranial pressure, Radiotherapy

Causes continued

- Medications – including opioids
- Hypercalcemia
- Local tumour
- Pepetic ulceration
- Motion sickness
- Vestibular disease

Treatment

- Anti-Emetics – important to ascertain WHAT kind of nausea - ?GIT ? Central ? Increased ICP

- GIT – Metoclopramide 10mg – 30 mins Before meal – moves/clears the gut better than other AE's
  - D2 Antagonist, well documented in treating delayed gastric emptying and opioid induced nausea
  - Side effect can be restlessness/agitation

Treatments continued

- Central – Haloperidol 0.5 – 1mg BD, can cause sedation/rigidity
- Levomepromazine 6.25mg - 50mg orally every 4-8 hours. Or sub-cut 6.25 – 200mg/24 hours (less than 25mg = less sedating). Can cause hypotension
- Increased ICP – Cyclizine 12.5 – 50mgTDS or Dexamethasone 4mg
- Last resort – Ondansetron as it contributes to constipation

Non-Pharmacological Treatment

- Reduce spicy/fatty foods and decrease food volume/sitting upright for meals
- Mouth care/hygiene
- Guided meditation/relaxation
- Cognitive Therapy
- TENS machine
- Appetite stimulants – ginger ale, coffee, alcohol!

Treat reversible causes

- Drug toxicity – check medications, GP review, cease offending medication
- Bowels – ensure appropriate regime is in place and adhered to. Explain that bowel obstruction/partial obstruction will cause nausea and crampy abdominal pain, that may radiate
- Corticosteriods may reduce tumour mass, therefore nausea

Respiratory Symptoms

- Dyspnoea
  - If reporting that a Palliative client is SOB – Dr Broadbent would like O2 sats
  - Respiratory Secretions
  - The 2 main respiratory symptoms at EOL, can be sensory or affective

Respiratory cont..

- Sensory Symptoms – air hunger, work/effort, chest tightness. Common in MND, Lung disease. Intercostal muscles become fatigued, altered Vagal signals
- Non-pharmacological treatment – acknowledge that this causes distress
  - Fan therapy, education, mastery/self-efficacy, pulmonary rehab, reduce anxiety – psychology. CBT, pursed lip breathing, body position

Dyspnoea Treatment

- Pharmacological – Benzo's (Lorazepam, Alprazolam. EOL – Midazolam
- NOT Oxygen – this is used to treat hypoxemia NOT dyspnoea. Unless specifically indicated - risk of hyperoxaemia

Secretions/Rattles

- Comes in terminal phase/inability to swallow/clear – can be Salivary or Bronchial
- Skin colour/temp changes, death likely within 24 hours
- Does not happen with ALL patients – more likely in patients with bronchial obstructions, pulmonary oedema/fluid overload, brain tumours, stroke, PD, MND

Secretions - Treatment

- Education, reassure family re noise/fear of choking
- Positioning, turn on side if indicated
- Very rarely- gently suctioning – not always available in home setting
- Reduce fluids
- Mouth care – moisten mouth
- Pharmacological treatment doesn’t always work – can have side effects (over drying)
- Medications – Hyoscine hydrolomide, Buscopan, Glycopyrrolate, Atropine

Other ‘snippets’ relevant to our practice

- Have you heard of a Movi Bomb? – 8 sachets of Movicol in 1 ltr water, consumed within an hour
- If a patient deteriorates over months, then symptoms will worsen over months. If they deteriorate over weeks, then symptoms will worsen over weeks..stands to reason
- Increase in bowel activity = increase in energy, use of Creon for certain cancers to absorb nutrition from food = increase in energy

Snippets cont…

- Steriods cause acid stomach/reflux – will need Omeprazole or similar
- High Protein supplements (Sustagen, Resource, Ensure etc) – easier to absorb
- To be eligible for hospital bed/equipment through Pall Care OT, PCOC score must be 3/10/30 or less

Referrals to CPCS Allied Health

- Can be done via SBAR
- You are welcome to contact them directly by phone – they may or may not know the patient
- Allied Health Assistant (Joyce) does home visits – she can be referred to for things such passive ROM for MND patients

Pain – Different Ways to Assess

- Rather than asking for a number, ask:
- Is your pain distracting you?
- Is it stopping you from doing things?
- Does your prn medication work within 20 mins?
- What works?
- Consider medical review if appropriate

Oral Thrush

- Bi-carb soda
- Soft/baby toothbrush
- Consider getting bloods taken

Dexamethasone vs Prednisone

- Dex is 6 x more potent
- Pred works more quickly
- Dex can be used for nausea and to increase appetite
- Pred is more for respiratory symptoms
- Dex has a longer half life, but more likely to cause constipation
- Dex can be given in more varied routes

Finally!!!

- Morphine Conversion Tables
- Download an Opioid calculator on your phone
- I have the FPM/ANZCA one – lets all have a look now!