Symptom Control in the Community Setting

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Common symptoms

- Pain
- Agitation
- Shortness of breath
- Nausea and vomiting
- Intestinal obstruction
- Confusion

Pain

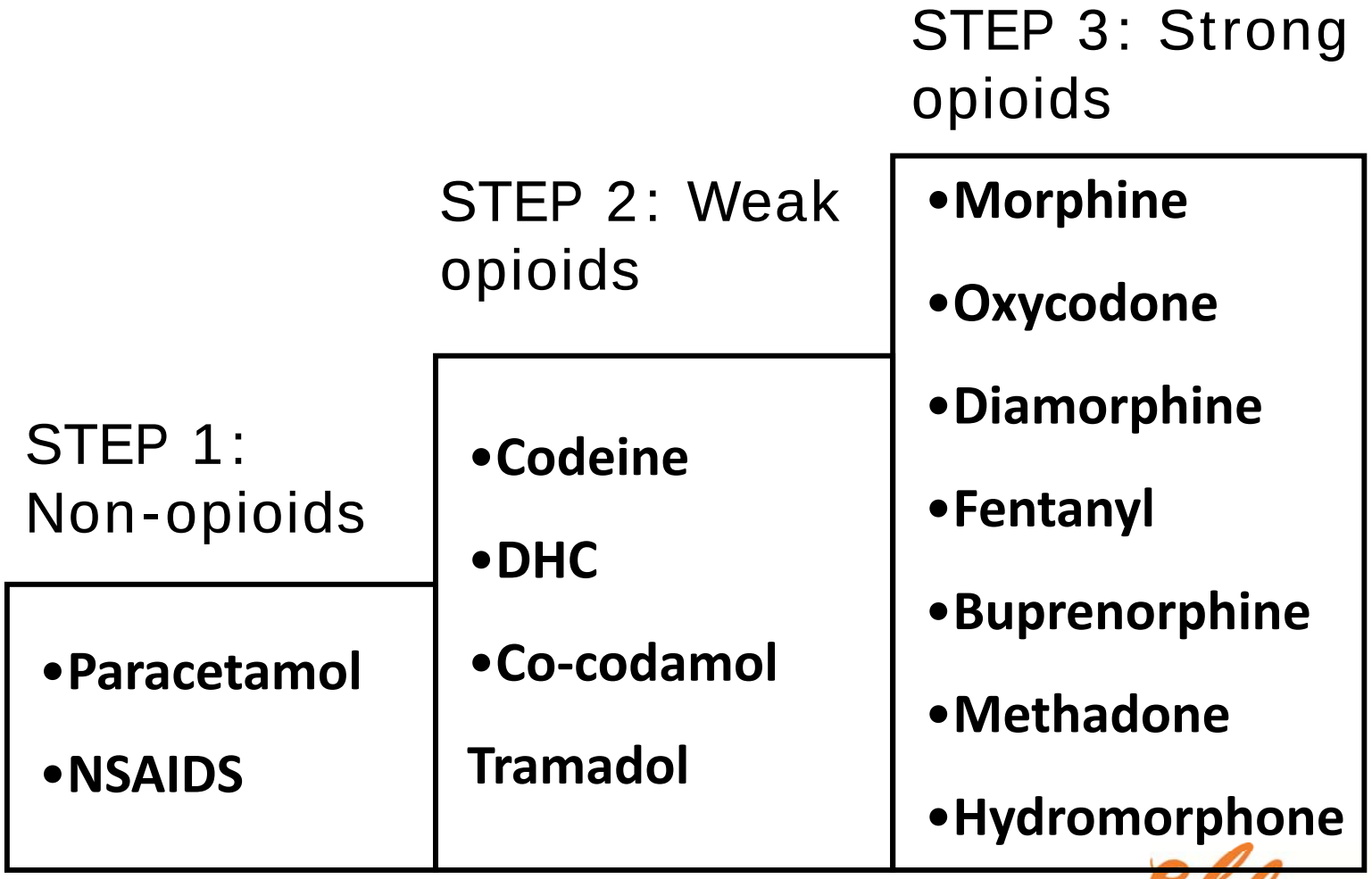
- Occurs in 60-70% with advanced cancer
- 50% have 2 or more pains
- 65% dying in hospital have significant or severe pain
- pain can be controlled in >80% patients.

Common types of pain in cancer

- Somatic or visceral pain
- Neuropathic pain
- Bone pain
- Incident pain

- NB TOTAL PAIN incorporates physical, emotional, social and spiritual

The WHO analgesic ladder



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Which opioid?

- Tailor to patient
- Previous experience
- Side effects?
- Route of delivery
- Compliance concerns
- Organ function
- Fears?
- Morphine remains the gold standard opioid

Starting morphine

- Oral whenever possible
- Regular dosing with a 4 hourly (qds) preparation and the same dose as a prn
- Titrate dose up
- If opioid naive start with 2.5-5mg 4 hourly
- Laxative – sodium docusate or movicol
- Consider anti-emetic

Titration

- Start oral morphine liquid 5mg qds plus prn 5mg
- Patient has 20mg regular plus another 20mg in 4 prns = 40mg total
- Increase regular to 10mg qds plus prn 10mg
- If not more prns used or just occasional then convert patient to slow release morphine 20mg bd
- If still needing few prns per day continue to titrate with oral morphine liquid

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Opioid liquid concentrates

- Oral morphine standard strength 10mg/5ml
- Also comes in concentrate 20mg/ml
- So 40mg of standard is 20ml and of concentrate is 2ml
- Oral oxycodone liquid standard strength 5mg/5ml
- Also comes as concentrate 10mg/ml
- Many errors have occured recently in the community
- Don’t swap patient strengths unless absolutely necessary and patient and family fully understand
- PRESCRIBE AS MILLIGRAMS NOT MILLILITRES

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Patches

- Good for stable pain
- Not good for acute pain – take 24-48 hours to reach steady state
- Expensive – use when appropriate, if patient can't swallow, poor oral absorption, non-compliant, nausea and vomiting
- Consider dose very carefully in opioid naïve patients
- Understand the dose equivalence to morphine

- If patient has little or no sub cut fat then patch unlikely to work as they get absorbed through the fat

Fentanyl patch

- 12, 25, 50, 75 and 100 mcg/hr sizes
- Change every 3 days
- Every 25mcg fentanyl is equivalent to 90mg oral morphine

Buprenorphine patch

- 2 types – Bu-Trans and Transtec

- Bu-Trans – 5, 10 and 20 mcg/hr sizes
  - change every 7 days
  - 10mcg/hr patch equivalent to maximum dose co-codamol 30/500, 2 tablets qds

Please don't stop maximum co-codamol and only put the patient on a 5mcg Bu-Trans, it is less analgesia than what they had

- Transtec – 35, 52.5 and 70 mcg/hr sizes
  - change every 4 days

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Neuropathic pain

- Nerve damaged
- Description – burning, shooting, allodynia etc
- Distribution
- Mood
- Sleep disturbance
- Identify early – often harder to manage
- Opioids less useful
- Needs different drugs
- Some patients may need early referral to a pain anaesthetist

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Adjuvant analgesia – Drugs for neuropathic pain

- Antidepressants: Amitriptyline, duloxetine
- Anticonvulsants: gabapentin, pregabalin, sodium valproate
- Steroids
- Others : Clonazepam, methadone, lignocaine, ketamine
- Regional nerve blockade
- Epidural analgesia
- Please don’t think they are not important and stop adjuvant’s as patients pain can rapidly worsen with knock on effects

Bone pain

- NSAIDS
- Opioids especially good is methadone
- Bisphosphonates
- Denosumab
- Radiotherapy

Incident pain

- On movement, dressings, showering etc
- Short acting analgesia – fentanyl sublingual tablets and nasal sprays
- Dressing changes – opioid +/- midazolam

Agitation

- Can see at the end of life but also earlier
- Can be hard to manage
- May need medication – haloperidol, lorazepam, diazepam and may need these in large doses
- Often goes under-recognised and under-treated
- Causes families lots of distress and they will remember this when the patient dies and can cause bereavement issues

Breathlessness – causes

  - Specific cancer/terminal illness eg: SVCO, lymphangitis, pleural effusion, ascites
  - treatment related eg: radiation fibrosis, chemo induced, drugs
- General causes eg: anaemia, weakness, pneumonia pulmonary embolism
- Anxiety
- Other co-morbidity eg: COPD, heart failure, pulmonary fibrosis

Breathlessness – treatments

- Treat cause if possible and appropriate
  - chemo or radiotherapy
  - antibiotics
  - bronchodilators
  - Diuretics
  - Anti-coagulants
  - pleural aspiration / drain / pleurodesis
  - blood transfusion

Breathlessness – treatments

Non-pharmacological:

- sitting upright, loosen clothes, cool environment
- stream of air, drafts – fan, open window
- reassurance
- company
- Relaxation
- breathing exercises – concentrate on exhale
- Hypnosis

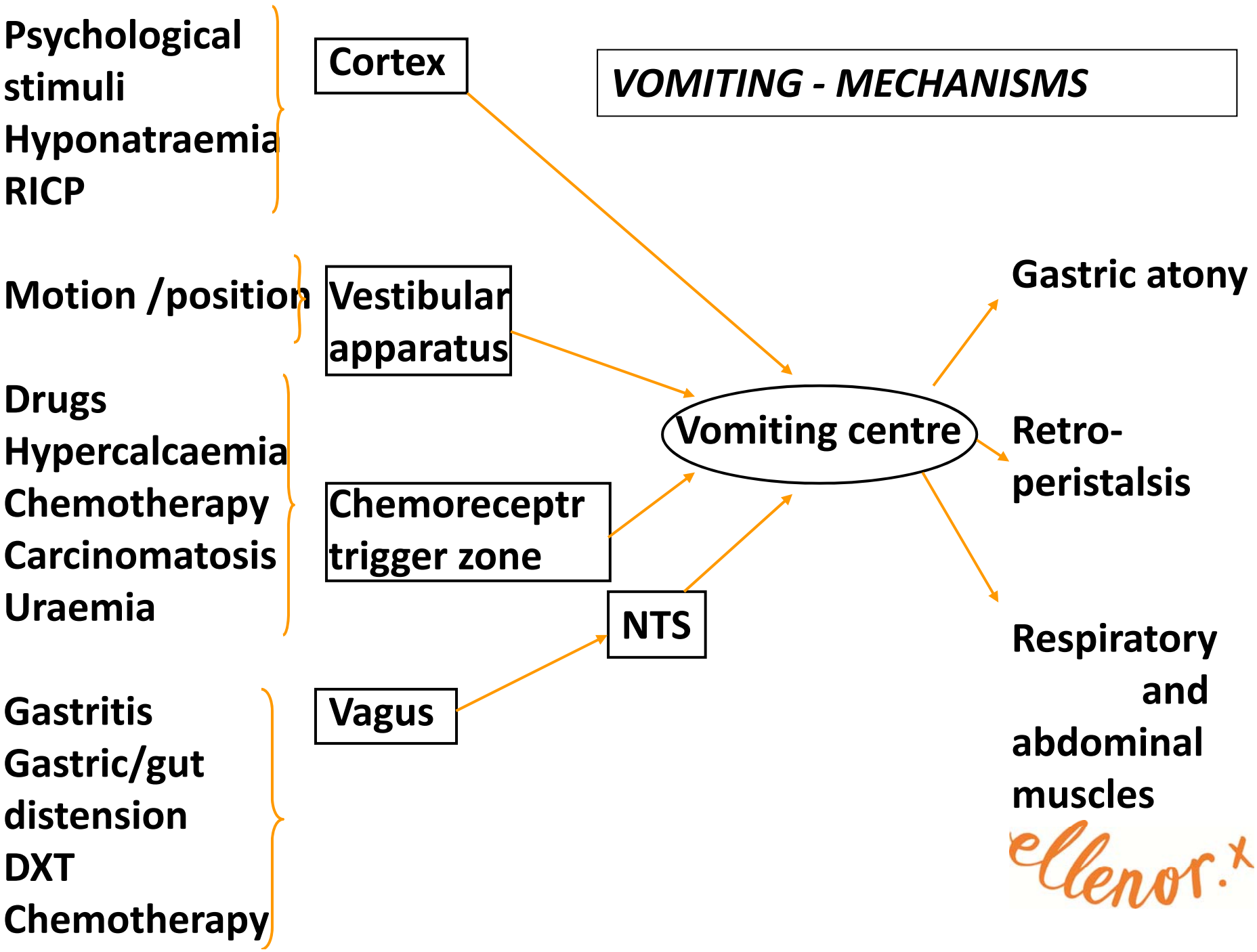
Breathlessness – treatments

Pharmacological:

- Inhalers/nebulisers – salbutamol, ipratropium may help
- Oral morphine - start low dose 2.5 - 5mg every 4 hours plus as needed
- Lorazepam – 0.5 - 1mg sub-lingually, up to 4mg daily
- Use of the two together has additional benefit
- Little point in telling patients to stop smoking at this stage

Nausea and vomiting

- Nausea and vomiting occur in 40-70% of advanced cancer
- Can be controlled in at least 80%
- Very debilitating for patients
- Will often stop them eating
- Lots of causes


VOMITING - MECHANISMS
Psychological stimuli
Hyponatraemia
RICP
Cortex
Motion /position
Vestibular apparatus
Drugs
Hypercalcaemia
Chemotherapy
Carcinomatosis
Uraemia
Chemoreceptr trigger zone
Gastritis
Gastric/gut distension
DXT
Chemotherapy
Vagus
NTS
Vomiting centre
Gastric atony
Retro-peristalsis
Respiratory and abdominal muscles
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Management of nausea and vomiting

- Assess nausea and vomiting separately
- Treat reversible factors
- Consider non-drug treatments
- Select 1st line drug and appropriate route
- Re-evaluate regularly including doses
- Add or substitute second line drugs

First line anti-emetics

Delayed gastric emptying ?

- Use PROKINETIC e.g. Metoclopramide 10-20mg tds

- Pancreatic mass
- Ascites
- Hepatomegaly etc

First line anti-emetics

Chemical causes ?

- Use DRUG ACTING ON CTZ e.g. Haloperidol 1.5mg od/bd

- Drugs,
- Sepsis,
- Metabolic – calcium, uraemia etc

First line anti-emetics

Direct stimulation of vomiting centre?

- Use DRUG ACTING ON VOMITING CENTRE e.g. Cyclizine 50mg tds

- Raised intracranial pressure
- Radiotherapy to brain etc

Other drugs for nausea and vomiting

- Levomepromazine – good second line drug as acts at vomiting centre 6.25-12.5mg od/bd
- Steroids
- Benzodiazepines – decrease anxiety
- Granisetron/ondansetron – 5HT3 antagonists - used with chemo

Intestinal obstruction

- Colicky pain or constant pain
- Nausea, constipation, not passing wind
- Can pass small amounts of faeces if sub acute obstruction
- Can vomit large amounts, sometimes faecal
- Won’t absorb oral drugs
- Need to dry up secretions

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Intestinal obstruction

Causes:

- Disease progression - mechanical
- Constipation - functional
- Establish cause before deciding line of treatment
- Consider syringe driver
- For some patients a more active route of treatment is appropriate and so surgical opinion may be sought. For some this may prolong there lives by many months

Intestinal obstruction – treatment

- 1st line – Cyclizine 150mg in syringe driver or haloperidol 3-5mg in SD
- 2nd line – Levomepromazine 12.5-25mg in SD
- Opioid – morphine 10-40mg in SD
- Hyoscine butylbromide (buscopan) 60-120mg in SD
- Octreotide - expensive
- Nasogastric tubes
- Surgery – colostomy can prolong life

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Confusion

Delirium

- Infection
- Drugs
- Metabolic – dehydration, uraemia, hypercalcaemia
- Pain
- Constipation/Urinary retention

Dementia

Confusion – management

- Quiet environment
- Bladder/bowel care
- Treat reversible things like hypercalcaemia if appropriate
- Temperature control
- Address psychological distress
- Company
- Support carers

Confusion

Benzodiazepines

- Lorazepam 0.5-1mg, diazepam 2-5mg bd/tds and midazolam 2.5-5mg prn,

Phenothiazines,

- Haloperidol 1.5-3mg od/bd/tds, levomepromazine

Phenobarbitone (consult specialist palliative care)

Any questions?

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for families facing terminal illness