# PRINCIPLES OF SYMPTOM MANAGEMENT

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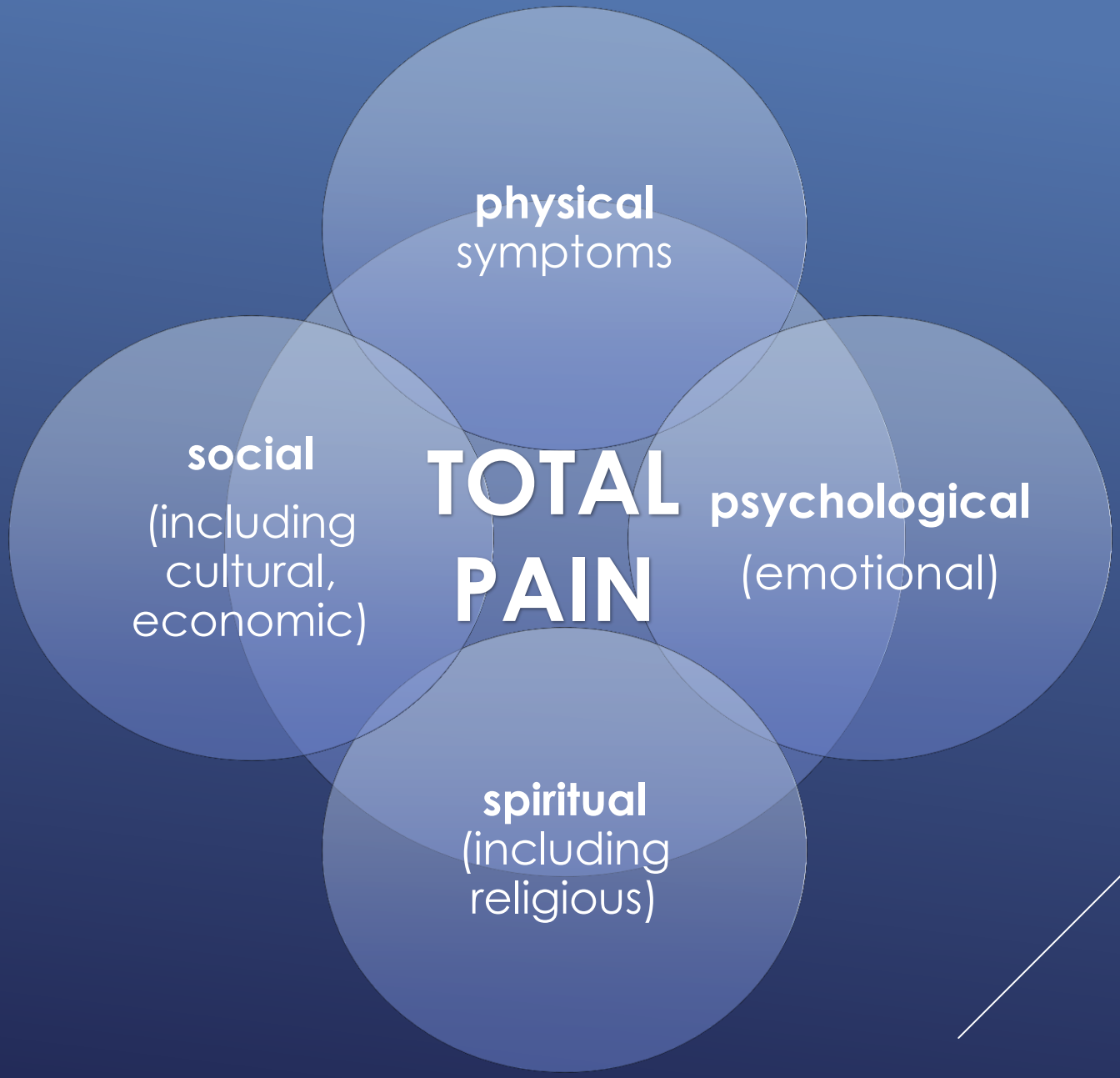
# WHO DEFINITION OF PALLIATIVE CARE

- "….an approach that **improves the quality of life** of patients and their families facing the problem 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**"

http://www.who.int/cancer/palliative/definition/en/

# multiple dimensions of suffering




based on the late Dame Cicely Saunders's concept of total pain

- physical and/or psychological symptoms
- distress & impact on quality of life
- social / cultural / spiritual / religious context
- medical background, co-morbidities, past medical history, medications, allergies, examination, previous investigation results

# IDENTIFICATION & IMPECCABLE ASSESSMENT

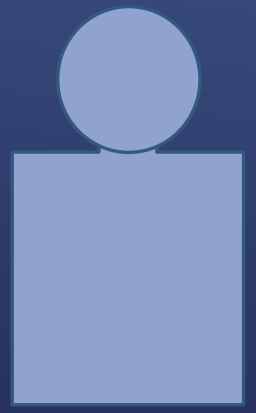
# PRELIMINARY MEDICAL CONCERN

- clues in environment regarding symptom issues
- handover from referrer
- common to have pre-formulated ‘idea’ of specific set of physical symptom(s) to focus on

main concern(s)

= or ≠

main concern(s)



**patient**

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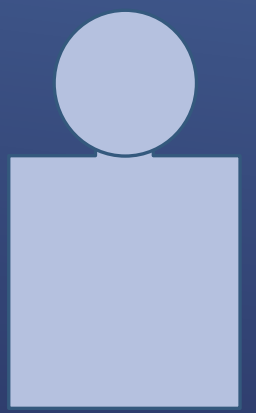
mindful that patient & clinician's 'agendas' or 'concerns' may not align



**nurse / doctor**

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# PATIENT-CENTRED CONCERNS

- **what is most important for individual patient?**
- always try to address main symptom concern for patient
  - however also assess for ‘red flags’

- if symptom significant for patient and/or carers or family members, it should be acknowledged
- collateral history often helpful
- frame that understanding of symptom issue(s) within individual patient's psychosocial context

# "ASK & YOU WILL DISCOVER…"

# "GOOD COMMUNICATION SKILLS…"

- empathic, non-judgmental listening, having time and patience, significance of presence

# GENERIC MODEL OF PHYSICAL SYMPTOM ASSESSMENT

- onset / timing / constant / intermittent / similar or identical symptoms in past
- precipitating / exacerbating / relieving factors
- specific characteristics of particular symptom(s)
  - eg. site on body & extent for pruritus

# GENERIC MODEL OF PHYSICAL SYMPTOM ASSESSMENT

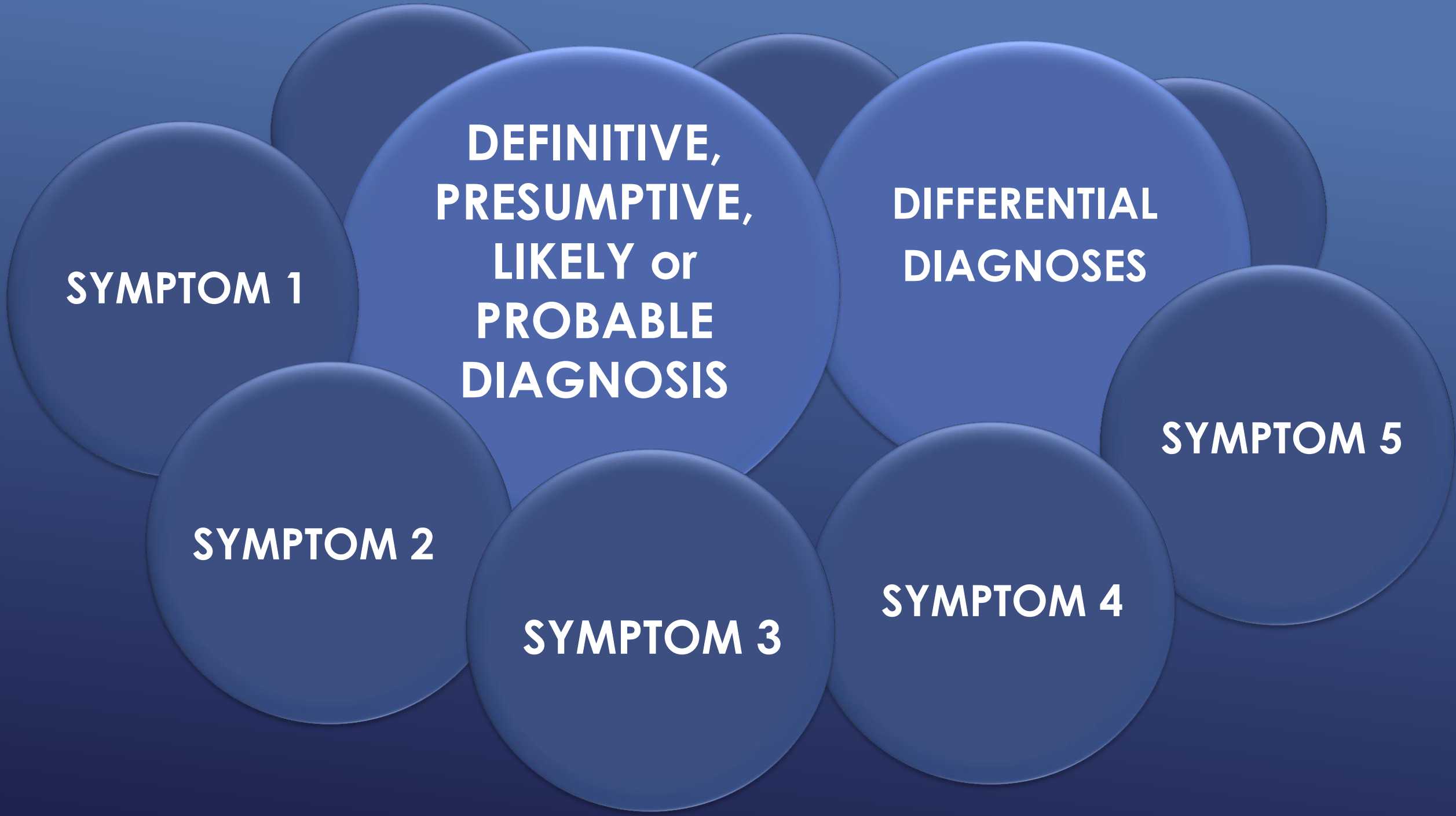
- association with other symptoms (timing may be important)
- severity (including over time) & impact on functioning & quality of life
- previous therapies & response(s)?
- **physical examination**

# SYMPTOMS MAY FOLLOW PATTERNS

- reality usually >1 symptom & myriad of symptoms can pose diagnostic, management challenges
- symptom constellation often categorisable
  - eg respiratory, gastrointestinal, infective symptoms
  - often follows ‘patterns’ suggestive of a particular medical issue / diagnosis

# WHY USEFUL?

- generally processing information, trying to understand likely underlying cause(s) for symptoms
- usually appropriate to attempt treatment of easily reversible medical conditions which require ‘low burden’ therapy
  - however ensure consistent with goals of care / preferences of patient


SYMPTOM 1
DEFINITIVE, PRESUMPTIVE, LIKELY or PROBABLE DIAGNOSIS
DIFFERENTIAL DIAGNOSES
SYMPTOM 2
SYMPTOM 3
SYMPTOM 4
SYMPTOM 5

# MR XYZ

- 60 year old retired teacher with metastatic non-small cell lung cancer with right hilar disease
- chemotherapy ceased 6wks ago
- main symptom : 1mth central nausea with occasional small vomits, worsening over past 2wks
- associated ↓ appetite & oral intake, mild fatigue, bowels regular, no pain issues

- precipitated by smells of food esp. wife's cooking, small house with limited windows
- had not said anything to wife or family who are extremely concerned & anxious about ↓ po intake
- worried that wife (a chef) would be offended, normally he would hover close to kitchen waiting for her food to be served

# SOCIOCULTURAL CONTEXT

# APPRECIATING THE CONTEXT

- discussion with Mr XYZ & family, more understanding afterwards
- encouraged to sit in his little garden outdoors rather than remain indoors when wife cooking
- also given option of antiemetic for central nausea
- nausea & eating improved

# PROGRESS - MR XYZ

- 6 weeks later follow-up visit, discover that Mr XYZ unwell, breathless & productive cough (greenish phlegm) in past 4-5 days, fevers past 2 days
- wife reports he complained of mild dysphagia & noticed Mr  XYZ coughing with fluids for past week

# EXAMINATION

- BP 120/85, HR 110, T38.2, SpO2 90% room air, RR 28
- cachexia, mildly dry mucous membranes
- right lung base bronchial breath sounds & crackles
- nil signs of peripheral fluid overload or DVT
- admission to hospital

# LIKELY ISSUE / DIAGNOSIS

- constellation of symptoms & signs :
- likely aspiration pneumonia, RLL pneumonia
- blood tests, sputum m/c/s and/or CXR
- oral antibiotics, bronchodilators, oxygen
- Mr XYZ clinically improving with therapy

# PATIENT PREFERENCES

- speech pathology recommend thickened fluids
- discussion with Mr XYZ & family :
  - Mr XYZ who prefers to continue on thin fluids for quality of life, accepting risk of recurrent aspiration pneumonia
  - thus allow comfort feeding

- 68 year old married woman with end-stage kidney disease secondary to diabetic nephropathy, on haemodialysis 3x / week
- despite optimal renal medical management, still has symptom issues
- lives with family, some conflict, ‘cranky’ at home

# MRS ABC

- worsening of chronic symptoms :
- generalised pruritus since >10mths ago
- painful burning in both feet esp. at night for ~8mths
- restless feeling in legs at night since 3 months ago
- associated insomnia for at least 2 months
- no effect : various creams, steroids, anti-histamine

# FRUSTRATED, ANGRY…

# CLINICAL ASSESSMENT

- uraemic pruritus
- peripheral neuropathy secondary to diabetes or renal failure
- restless leg syndrome
- significantly affected quality of life, functioning, relationships

# HOW WILL YOU HELP?

- liaise with nephrologist
  - already seen dermatologist in past (“unhelpful”)
- clinical psychologist
- diversional therapist
- medication trial?

# THERAPY OPTIONS

reasonable to use either gabapentin or pregabalin

some evidence suggest may be helpful (mindful variable quality of evidence)

# STRATEGY EMPLOYED

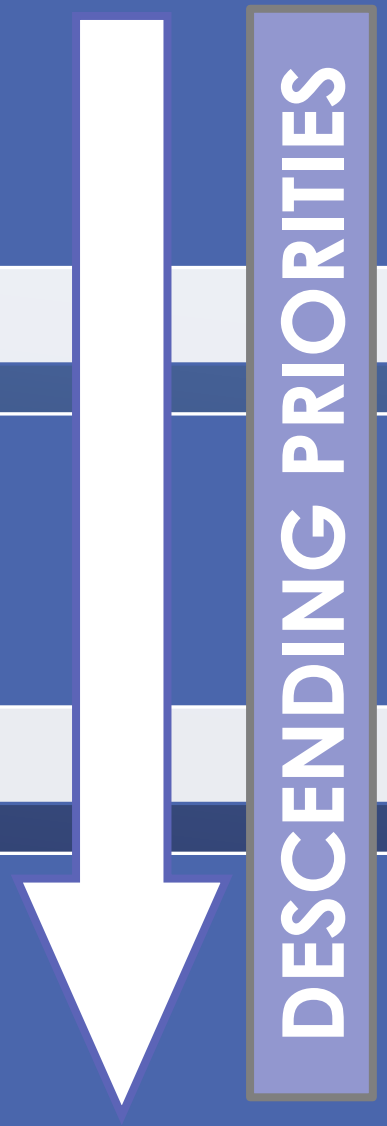
- discussion with Mrs ABC & her family :
- realistic expectations of possible benefits, monitor for side effects
- commenced gabapentin 100mg 3 times a week, after haemodialysis; liaised with doctors & nurses
- f/u visit, significant improvement in symptoms, tolerating well, better relationships

- good symptom management require good assessment & prioritization of medical / symptom issues

Medical / Symptom Issue #1

Medical / Symptom Issue #2

Medical / Symptom Issue #3



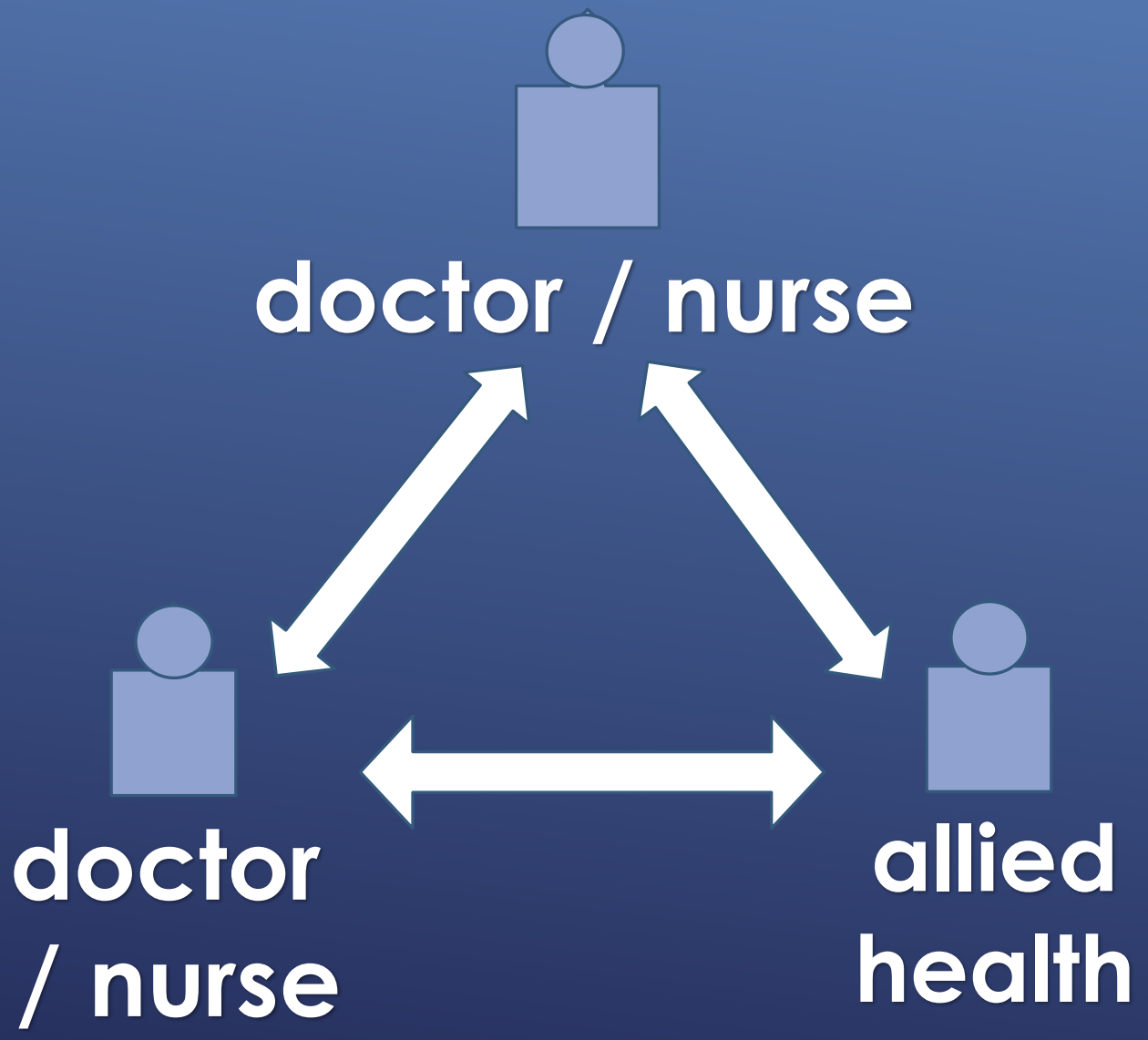
- consider appropriateness of further Ix and/or Tx of underlying reversible condition(s) responsible for symptoms
  - symptoms often multifactorial

- patient-focused concerns / centred care
- good communication skills, presence

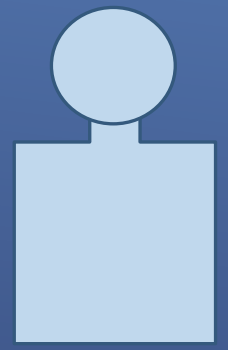
- apply clinical knowledge & experience
- select specific pharmacological agent(s) & dosing most suited for individual patient, considering co-morbidities & circumstances*

- assess response(s) and tolerability (adverse effects) of treatment on ongoing basis
- recognise dynamic nature of symptoms & medical condition in general

- importance of communication and/or collaboration with other healthcare professionals



- multidisciplinary team involvement whenever available & appropriate – provision of holistic care



nurse
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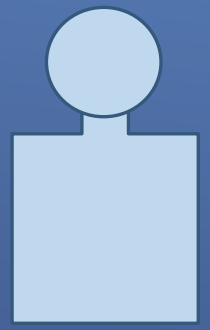
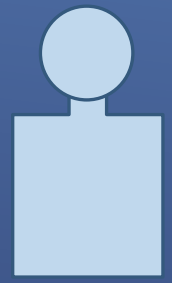
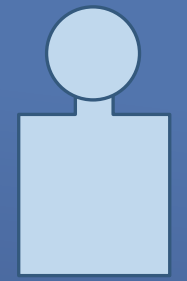


occupational therapist

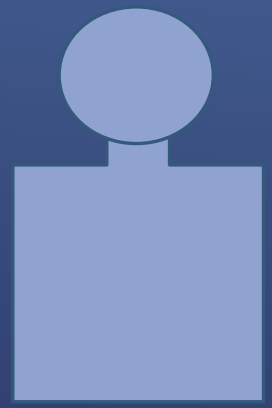


social worker

dietician



speech pathologist



**patient**
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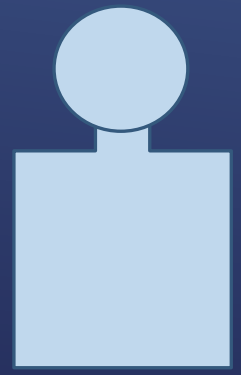
clinical psychologist



doctor
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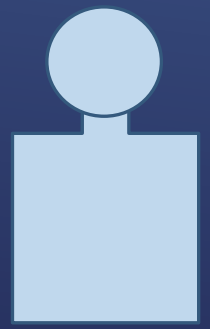
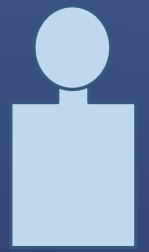


physiotherapist



diversional therapist

pastoral care

energy conserving techniques

relaxation techniques

cupping

meditation

aromatherapy

dietary modification

art therapy

- **management NOT always pharmacological !!!**

Tai-chi

dignity therapy

acupressure

reiki

music therapy

hot packs

ice packs

acupuncture