



ICE BREAKER

# Common Palliative Symptoms



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# Aim of Session

- To identify symptoms that are common in palliative care
- To explore the management of these symptoms in clinical practice

# Common Symptoms in Advanced Cancer

• Weakness	95%	Dry/Sore mouth	50%
• Pain	80%	Nausea	40%
• Anorexia	80%	Vomiting	40%
• Constipation	65%	Anxiety	40%
• Dyspnoea	60%	Cough	30%
• Insomnia	60%	Confusion	30
• Sweats	60%	Itch	5%
• Oedema	60%	Diarrhoea	5%

# Management objectives for Nausea & Vomiting, Confusion & Itch

- Evaluation to identify causes(s)
- Treatment of reversible causes
- Non Pharmacological management
- Pharmacological management

Itch  
Itch





## Severe Itch in Advanced Disease

- ❖ Biliary obstruction
- ❖ Drug Induced
- ❖ Medical – Chronic Renal Failure, Diabetes
- ❖ Haematological
- ❖ Fungal Allergy

# Itch

## Topical Treatments

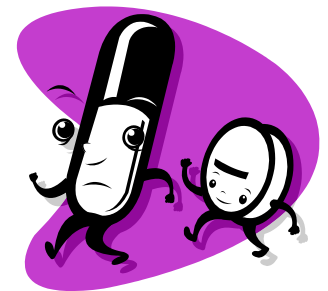
- ❖ Aqueous cream and menthol 1-2%
- ❖ Oily calamine lotion with 0.5% phenol
- ❖ Antihistamine creams – prolonged use may cause contact dermatitis





## Pharmacological Management

- ❖ Dermatitis- 1 % Hydrocortisone for up to one week
- ❖ Ondansetron – useful for opioid induced itch and uraemia.
- ❖ Antihistamine Tablets – Piriton and phenergan, non sedating Loratadine and Triludan.
- ❖ Malignant Disease/Cholestasis/ Ureamia/ Opioids – Paroxetine
- ❖ Night Sedation



# Nausea & Vomiting



# Evaluation –clinical pictures & causes

## Chemical / metabolic

- Severe persistent nausea
- Little relief from vomiting
- Small volume vomitus and / or retching.

## Bowel obstruction

- Intermittent / mild nausea
- Nausea often relieved by vomiting.
- Large volume vomitus
- Upper GI : early satiety, vomit after meal, undigested food.
- Lower GI: faeculent vomitus, associated symptoms, colic

## Raised intracranial Pressure

- Intracranial malignancy
- Cranial Radiotherapy

## Movement Related

- Vestibular disease
- Transport

# ANTI -EMETIC MEDICATION

## FIRST line drugs

- **Metoclopramide** 10mgs tds po / 30-60mgs CSCI  
-GI obstruction without colic.
- **Haliperidol** 1.5 mgs -2.5mgs od/po /3-5mgs CSCI.  
- Chemical causes including opioids , renal failure.
- **Cyclizine** 50 tds po / 100-150mg CSCI.  
-Raised intracranial pressure, motion induced.

## • SECOND line drugs

- **Levopromazine** 6-12mg od po/sc  
Unknown or multiple causes, anxiety related.

## **Granisetron** 1mg od/bd/po/sc

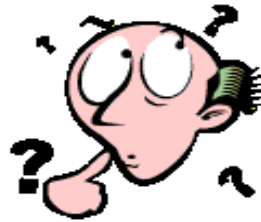
- Chemical changes, GI obstruction RT involving bowel.



# Miscellaneous drugs

- **Hyoscine butylbromide 60- 120mgs**  
Mechanical GI obstruction (first line)
- **Octreotide - 300- 600mcg**  
Mechanical GI obstruction (second line)
- **Dexamethasone – 4-8mg po/sc**  
Raised intracranial pressure. GI obstruction.
- **Benzodiazepines**  
Anxiety –induced symptoms

# CONFUSION



# ASSESSMENT & PHARMACUTICAL MANAGEMENT

- LASTING MEMORY FOR FAMILY
- REVERSIBLE CAUSE
- LENDS ITSELF TO SPEEDY TREATMENT IF APPROPRIATE



- BENEFICIAL FOR PATIENT AND RELATIVES FOR PROMPT ASSESSMENT AND SEDATION
- S/C INFUSION

**MIDAZALAM 10-100MG/24 HOURS**

TO CONTROL ANXIETY AND AGITATION MIXES WITH **DIAMORPHINE AND CYCLIZINE** IN SYRINGE DRIVER

- REVIEW MEDICATION/CONDITION 24 HOURS

CONSIDER OTHER MEDICATION  
e.g NOZINAN 25MG-150MG

# Recipe

## Ingredients

- 1 Confused patient**
- 5 Distressed family members**
- 1 hospital room, with light switch**
- 3 morning nurses, 2 afternoon nurses, 2 night nurses**
- 1 ward doctor, 1 on call doctor**
- 2 large hospital porters**
- 1 syringe of chlorpromazine**
- 1 green hypodermic needle**
- 1 wardful of assorted patients**





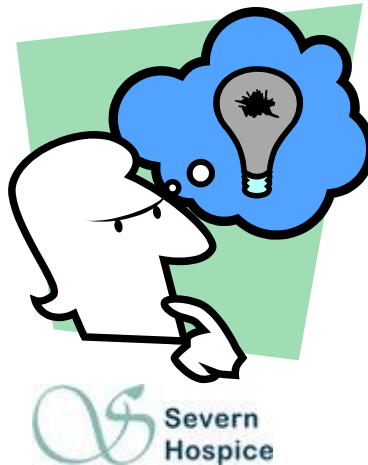
# Method

Remove the confused patient from his or her familiar bedroom at home, and place in cold hard in unfamiliar hospital room.

Ask family to leave the room. Ward doctor should examine patient. After eight hours switch off lights. Leave patient in a dark room and disturb regularly. When he or she protests send for the on call doctor. Wait until patient becomes frightened.

When he or she begins to rise over the bed apply one large hospital porter to each arm

Change nurses regularly



On call doctor should give injection of chlorpromazine into the patients bottom whilst repeating the incantation “ this wont hurt” or “this is for your own good”

Agitate the whole ward for four hours and await ward round. Repeat chlorpromazine if patient shows any sign of waking up.

Garnish with diazepam suppositories



**INFECTIONS:** RESPIRATORY, URINARY,  
MENINGITIS.



Intracranial Pressure,  
Tense Ascites  
Hiccups  
Movement related

**DRUGS:**

OPIOIDS, NSAIDS,  
CORTICOSTEROIDS,  
CIMETIDENE, DIGOXIN,  
HYOSCINE, ORAL  
HYPOGLYCAEMICS.

**TUMOUR:** PRIMARY,  
SECONDARY

**GENERAL:**  
CONSTIPATION,  
URINARY RETENTION,  
EXCESS HEAT / COLD,  
PRURITIS, COUGH,

**DEMENTIA**

**BIOCHEMICAL:** ALCOHOL, DRUG WITHDRAWAL,  
HYPERCALCAEMIA, UREAMIA, HYPOXIA, HEPATIC  
FAILURE, chemotherapy, Radiotherapy

**CVA**

# Group Brain storming case study

You are about to meet George , 65year old chap, recently diagnosed with metastatic colo rectal cancer.

## The Facts

- The disease is inoperable and George has refused chemotherapy.
- George is jaundiced and itching and feels sick.
- He has abdominal ascites and he is feeling constantly nauseated.
- George describes feeling full and bloated.



# References

- Peter Kaye “Pocketbook of symptom control” 1995
- NHS National Library for Health:  
[http://cks.library.nhs.uk/hiccups/quick\\_reference\\_guide](http://cks.library.nhs.uk/hiccups/quick_reference_guide)

Guidelines for the Management Of Itch in Palliative Care - Severn Hospice Guidelines/Audit form

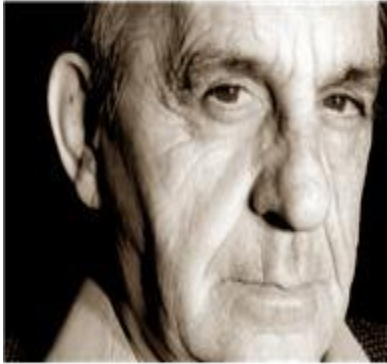
Frontiers in pruritus research: scratching the brain for more effective itch therapy. The Journal of Clinical Investigation. 116(5):1174–1186 Published May 1, 2006

New Research Shows Itch is A Lot More than Skin Deep  
03 February 2011 - Volume 11 - Issue 3 - pp 6-7

Pruritus in palliative care. Getting up to scratch. Canadian Family. 2011, vol57, p1010-1013



# Case Study - Charlie



A 72 year old man, Charlie has been referred to you, you are told that he has been diagnosed with Pancreatic Cancer, with mets in Liver and around gall bladder , he is experiencing severe itching and is scratching his skin so much that he has wounds.

What would your plan be?

# Case Study - Della

- Della has a brain tumour, she has had resection and completed Palliative radiotherapy.
- Della is taking oral Cyclizine 150 mgs, she is nauseated and vomiting once a day .
- She and her family are concerned.
- What can you suggest ?







# Case Study - Greg

- Greg is 45 years old, he has a rectal cancer.
- He was traumatised about the prospect of a stoma, fortunately his surgery was able to by pass this need.
- It has been identified that Greg has had undiscovered drinking addiction for many years, but firmly denies this.
- He develops faecal vomiting, extreme abdominal pain. Bloods are checked, he refuses admission he wants his vomiting controlled , his Gp wants admission, you have to advise options for sub cut and in the syringe driver as a compromise until he agrees to admission.

# Case Study - Maureen



- Maureen & Fred are 88 year old twins, both have lost their partners so live together.
- Maureen has longstanding mental health issues including Bi polar and early signs of Dementia that are currently under investigation.
- Maureen has a past history of Metastatic Lung Cancer , with Brain Mets
- Unfortunately Maureen has also been experiencing episodes of increased confusion, Fred is concerned, and so what can you advise ?

# Case Study - Brian

- Brian, 62years old, has returned to live in the UK after many living years in Spain. Brian was diagnosed in Spain with Metastatic Melanoma, involving Kidney, Brain and lung, he is pleasantly confused and experiencing ongoing uncontrolled vomiting.
- Brian is struggling to accept his diagnosis, it all happened very suddenly and he is not keen to take any conventional medication therefore this is contributing to his uncontrolled symptoms.
- He only has an elderly mother in the UK.
- So, what actions will you take ?



# Case Study –Daisy



- Daisy is a 64 year old retired Paediatrician, post retirement she was involved in a RTA and suffered a CVA as a result of head injuries, resulting in memory loss and epilepsy and has mobility / gait issues.
- What she thought was gallstones has been found to be Liver Disease, Primary Biliary Cirrhosis (non alcoholic).
- She feels fatigued, has abdominal ascites, intermittent nausea, increasing confusion and LFTs identify significant Liver Failure.
- A advanced care plan is in place identifying she does not want further investigations or admission, so how do you proceed / plan ?

# Case Study - Drew



- Drew is a 53 year old veteran from the Falklands War.
- On return to civilian life unfortunately Drew struggled to adapt to civilian life, he has spent much of the latter years living rough and now lives in a homeless refuge.
- Uncontrolled Type 1 diabetes resulted in Drew becoming a bilateral above knee amputee in a wheel chair.
- Drew now has Chronic Kidney Disease stage 5 / Renal Failure, not a candidate for Dialysis. He is experiencing nausea , vomiting , pruritus and fluid over load.
- Diabetes CNS, CMHT Substance Abuse Team and Renal Team are all involved. You have been asked to do a joint visit with the Diabetes CNS, for advice on symptom control.
- Prognosis – Drew has been told he has weeks to live.

# Case Study - Coral

- Coral is a 69 year old lady, recently widowed and just retired as a school cleaner.
- Coral has Chronic Kidney Disease and now has been diagnosed with Mesothelioma.
- Coral has Diabetic Retinopathy and is partially sighted
- Coral is very meticulous re taking her medication, however she is experiencing constant nausea and episodes of confusion. She is taking Bucastem for nausea.
- Her consultant has informed her that she has end stage disease – both conditions, and has been referred to Community services for Palliative care for input / assessment.



## Case study – Priscilla & George



- Priscilla is 91 and George is 92 years old, they live in a retirement home, and have been married 72 years , after being childhood sweethearts.
- Priscilla has Metastatic fungating breast cancer with widespread bone mets and until recently her disease had been stable however now her condition is deteriorating on a daily basis. Dn team visit daily to redress fungating wound and have observed that Priscilla is vomiting during their visit and ongoing through the day, Gp has prescribed Oral Metoclopramide 10mgs TDS.

# Case study – Priscilla & George



- George has Heart Failure, he has had CABG x 5 and previous MI s, persistent Atrial Fibrillation and thyrotoxicosis secondary to medication.
- He now has bilateral leg oedema with resulting Cellulitis and reduced mobility. Recently George experienced a manic episode and was admitted into hospital however no cause was identified.
- Since returning home George has increased confusion and forgetfulness- ? cause
- Social Services have assessed and a joint Nursing Home placement is pending, currently a care package is in place and their 8 children and families live locally and are very supportive visiting and staying over night.
- You have received a referral to visit and assess re their symptom management.