Palliative Care in Elderly

Bullets Points

- Palliative care is the holistic care of patients with advanced disease and limited prognosis.
- Palliative care is not just for patients with cancer.
- Palliative care should be provided by all doctors, however, a palliative care team should be available when required.
- Symptoms control is the most important aspect of palliative care.
- End of life decisions should be discussed in advance whenever possible.

Causes of Death in the UK

1% of population die each year, only 25% is caused by cancer, CVD 19%, Respiratory 14%, Stroke 11%, and others 31%.

Although most prefer to die at hospital, over 50% die at home, and that is why palliative care is an important aspect of geriatric medicine.

WHO Definition 2005:

The approach that improve the quality of life for patients and their families facing the problem associated with life-threatening illness, through the prevention and the relief of suffering by means of early identification and through assessment and treatment of pain and other problems—include physical, psychological and spiritual.

Palliative Care

- Palliative care provides relief from pain and other physical symptoms.
- Affirm life and regards death as a normal process.
- Intend neither to hasten or to postpone death.
- Integrates the psychological and spiritual aspect of patient care.
- Offers support system to help patients live as active as possible until death.
- Offers help system, for families.

Palliative Care in Elderly – Symptoms Management

Pain Management:

According to WHO pain relief ladder.

Start from non-opioid +/- adjuvant medication e.g. paracetamol 1gm qds and NSAID with consideration of neuropathic pain management like amitriptyline/gabapentin/pergabalin. We can also use topical NSAID and neuropathic topical painkillers like Zacin.

2nd stage: mild to moderate pain, to start on opioid +/- paracetamol +/- NSAID. Can use dihydrocodeine 30-60mg qds or tramadol 50-100mg qds. Combination are available like coddarmol 8-30/500

3rd stage: moderate – severe pain, to use regular, strong opioid like morphine e.g. oromorph 10mg/5ml prn and then to change to MST or to start with oxycodon and then change to oxynorm. Main SE are drowsiness, nausea/vomiting, constipation, respiratory depression, tolerance and addiction.
Recognizing sources of pain in cancer patients

1. Neuropathic pain, can use tricyclic antidepressant, like amitriptyline, imipramine, or using gabapentine and pergabaline. Valporate, ketamine, and TENS transcutaneous electrical nerve stimulation. Nerve block may be used.

2. Metastasis bone pain, NSAID/Morphine/bisphosphonate iv

3. Headache to increase ICP :- dexamethasone 16mg od and then reduce by 2mg daily. To maintenance of 4-6mg daily.

4. Nerve compression:- dexamethasone 8mg daily and local infiltration.

5. Stretching of liver capsule:- Prednisolone 25mg daily

6. Intestinal obstruction:- S.c hyoscine hydrobromide 0.6-2mg +octrotide.

Note :- Morphin are also available in patch form which is more favorable like, Buprenorphin (Butrans 5-20 Mcgm weekly). And fentanyl patch 25-75Mcgm every three days.

NAUSEA AND VOMITING:- appropriate anti-emetic , special care and thought should be given to specific causes like intestinal obstruction ,brain metastasis which require specific treatment.

INSOMNIA/ANXIETY/DEPRESSION:- Management with sedative like, zopiclone/zolpiderm/benzodiazepan/ and SSRI.

BREATHELESSNESS:- Consider chest infection, pleural effusion, pulmonary edema, and rattles. Treat underlying cause, could start hyoscine.

MOUTH HYGIENE:- drug adjustment, dental care, and dietary advise.

SPIRITUAL/ SOCIAL/PSYCHOLOGICAL SUPPORT.

CAUSES OF BREATHELESSNESS

Superior Vena cava obstruction.

Lymphangitis Carcinomatosis

The death rattle:- caused by excessive secretion in a patient with reduced LOC. Best respond to Hyoscine hydrobromide 400 ngm 4-8 hourly, most stressful to the family.

Pleural effusion:- usually recurrent, therefore require pleurodesis chemically by intrapleural tetracycline.

Other Causes like:- pulmonary edema, lung metastasis, bronchospasm, radiation pulmonary fibrosis,, require using diamorphine , diazepam,

OTHER PROBLEMS

Constipation , treat as usual ,use laxative, usually medication and poor mobility induced.if Intestinal Obstruction, use SC Diamorphin, Buscopan , and enema.

Insomnia –analyze cause

Hypercalcaemia

Ascites

Spinal cord compression –radiotherapy if diagnosed early
PROGNOSIS, WITHDRAWING, AND WITHHOLDING TREATMENT

prognosis is difficult to predict, cancer patients, doctors usually overestimate. In non cancer patients, like end stage COPD and HF it is even more difficult. The following might help in estimating the prognosis:-

1. clinical judgment,
2. performance status of the patient,
3. the presence of anorexia, weight loss, weakness,
4. SOB
5. Cognitive impairment and delirium
6. Lab test results “maltoni et al 2005, journal of clinic oncology). Physicians are not obliged to provide unnecessary treatment. Will of patient should explored early, discussion should involve family specially when patient get to the stage when he/she becomes unable to make that decision and not being stated in the will. CRP to discussed with patient, and the family. CRP SUCCESS RATE IS 10% in general condition and less than 1% in oncology.

URINARY INCONTINENCE

Introduction

• Urinary incontinence is a common condition that affects people of all ages and both sexes.
• Incontinence is defined as an involuntary leakage of urine.
• Up to 1 in 5 women and around 1 in 10 men over the age of 65 years suffers from incontinence.
• The prevalence increases with increasing age and co-morbidity. 2/3 of care home residence have incontinence.
• Incontinence can significantly affect a person’s wellbeing. Incontinence restrict social activities. It is the second cause after dementia to end old people into residential homes. Incontinence cost the UK government £ 420 million per year.

Causes

Age related changes:

• Diminished total bladder capacity
• Diminished bladder contractile function
• Increase frequency of bladder involuntary contraction
• Reduced the ability to postpone voiding
• Vaginal atrophy
• Loss of pelvic floor and urethral sphincter musculature
• Hypertrophy of the prostate in male

Co morbidity

• Reduced cognition
• Reduce mobility
• Increase constipation
• Prescribe medication affect lower urinary tract or conscious level.

Reversible factors

• UTI
• Delirium
• Drugs diuretic, sedative and anticholinergic
• Polyuria
• Urethral irritability
• Bladder stones and tumours
Irreversible but treatable

- In male prostatic hypertrophy or carcinoma
- Overactive bladder
- In female stress incontinence
- Mixed

Incontinence Assessment

- History of onset and duration of problem
- Previous medical, surgical and gynaecological problems
- Medication
- Assessment of functional abilities.
- Examination of abdomen and rectum.
- Urinalysis
- Urea, electrolyte, creatinine, glucose, Ca++, and PSA in men.
- Post micturation bladder scan
- Measurement of urine flow (flow meter)
- Measurement of BMI

Types of Incontinence

- **Urge**: patient complaint of involuntary leakage of urine accompanied or immediately preceded by urgency. Caused by overactive bladder, symptoms are mainly frequency, urgency, and nocturnal urination with inability to delay voiding.
- **Stress**: involuntary leakage of urine on effort or exertion. By Cause mainly by weak pelvic floor muscle, incompetent urethra or raised intra-abdominal pressure. Symptoms is mainly leaking urine on exertion, coughing, laughing, or sneezing.
- **Mixed**
- **Voiding problem**: this characterized by increased detrusor pressure and reduced urinary flow rate. Caused by prostatic hypertrophy, detrusor failure (neurogenic bladder), faecal impaction.

Treatment

**General Measures**

1. Staying active
2. Losing weight if necessary
3. Drinking water rather caffeine or alcohol.
4. In hospital or care home, toilets should be clearly identified and walking aids or assistance available
5. Careers of people with dementia should be aware of non-verbal cues such as agitation or wandering.

**Urge incontinence**

1. Bladder drill going to the toilet at regular interval followed by Bladder training gradually extending the time between these intervals
2. Immediate release oxybutynin, but this is not well tolerated in older people as it is non-specific anticholinergic agent. S.E are confusion, dry mouth, blurred vision, constipation, urinary retention, postural hypotension, oesophageal reflux.
3. Extended-release preparation or antimuscarinic drug such as Oxybutanine M/R 5-10 mg daily, tolterodine (Detrositol) 2mg BD or detrositol M/R 4mg daily. Vesicare 5mg daily. Regurin 20mg daily or regurin M/R 60 mg daily.
4. Finally botulinium toxin