The care of dying men

JANA JEYAKUMAR AND DAVID FEUER

The care of dying patients begins long before they approach the last few days of life. The authors explain how advance care planning, involving the whole multidisciplinary team and supporting the family are as important as symptom control in the last few hours of life.

Recently published research in patients with metastatic non-small cell lung cancer has shown a clear benefit to the early involvement of palliative care (soon after diagnosis) in terms of quality of life and mood. There was also a survival benefit of about two months compared to a group who had standard care, which further supports an integrated approach. The American Society of Clinical Oncology published a provisional clinical opinion that ‘combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden’. The panel felt this would improve symptoms and quality of life and reduce the burden on carers. The panel could find no negative outcome as a result of involving palliative care services.

Many patients who are nearing the end of life are well supported and managed by their medical care teams, whether they are at...
Some patients may wish to make an advanced decision to refuse treatment (ADRT). This is a legally binding statement that can be written or verbal. It is a decision relating to the refusal of a specific treatment in a specific circumstance. It comes into effect only if a patient loses capacity, in which case it must be followed if it is valid and applicable in the circumstances. If patients wish to make an ADRT, this should be done under the guidance of a person who understands the processes involved. A poorly written ADRT can cause confusion and could make it difficult for the medical team involved to understand a patient’s wishes. There have been documented cases of ambiguous ADRTs leading to treatment that the patient would not have wanted.

Advanced care planning requires effective communication between the members of the multidisciplinary team. This can involve highlighting to the primary care team that the patient should be placed on the Gold Standards Framework Register. This is an evidence-based approach to optimising the care for patients nearing the end of life. It requires that patients in the last year of life are identified. They are then assessed so that their priorities of care are established. Plans are then made to aim to achieve these priorities. For example, if a patient has chosen to die at home, a priority would be to ensure that the correct medications are in place.

The Liverpool Care Pathway

An holistic approach to end-of-life care is vital to ensure the best possible care for patients and their families. Care of the dying patient includes appropriate physical, social, cultural and spiritual care.

A vital step to managing end-of-life care is diagnosing dying. It is important to diagnose death promptly to allow appropriate care to begin and the patient’s family to prepare. Diagnosing death can be difficult. Common signs that a patient is approaching death include:

- increasing weakness and perhaps bedbound
- semi-comatose

Figure 2. Appropriate care near the end of life. Adapted with permission from RAND Corporation
• unable to manage oral medication
• managing to drink only sips of water.

A useful skill is to determine how the patient has been over the preceding few days and to establish whether there has been a change in condition and a progression toward becoming bedbound and less rousable. The diagnosis must be made within the context of a knowledge of the natural history of the disease and investigations and blood tests if appropriate.

The Liverpool Care Pathway (LCP) is commonly used in the UK for patients who are believed to be in the last 72 hours of life. It was developed with the aim of transferring hospice-type care into other settings such as a hospital, nursing home or a patient’s own home. It was developed in Liverpool by the palliative care team based there and by the Marie Curie Centre in Liverpool.10

The LCP is a multiprofessional pathway that provides a framework for providing effective end-of-life care. In the UK it is a key recommendation by NICE in its supportive and palliative care guidelines.11 It offers guidance on providing optimal comfort measures and symptom control, focusing on providing multidisciplinary care and improving communication between the interprofessional team.

A patient is considered appropriate for the LCP if the multiprofessional team agrees that the patient is dying. Once on the pathway, the LCP promotes an initial assessment, which involves reviewing medication and discontinuing unnecessary medication. There is also a focus on converting medication that needs to be continued to the subcutaneous route, if possible.

The LCP identifies four common symptoms at the end of life:
• pain
• nausea and vomiting
• agitation
• respiratory secretions.

The pathway suggests that subcutaneous medication that can be used to treat each of these symptoms is prophylactically prescribed on an as-required basis, even if the symptom is not present at the time of the initial assessment. If a symptom is present, it should be treated using a subcutaneous infusion if appropriate.

The LCP requires regular, four-hourly assessment of the patient to ensure he is comfortable. If a patient is not comfortable, action must be taken to improve comfort and this requires a multiprofessional approach. Examples of actions that can ensure comfort are alterations to medication or insertion of a catheter if a patient is in urinary retention.

If patients are no longer able to take their usual oral, symptom-control medication, a syringe driver can be used. This is a small, battery-driven pump that can provide a continuous subcutaneous infusion of medication. The medication used can be for pain control, nausea, agitation or respiratory secretions. Often a syringe driver contains more than one medication to treat a number of symptoms at the same time. Syringe drivers require skilled nursing staff to set up and monitor their function, with appropriate competencies maintained.12

SYMPTOM CONTROL

Advanced disease of any cause is debilitating and symptom control is a vital part of end-of-life care. Patients may have numerous symptoms and each person is affected differently. Careful assessment of the patient and his symptoms is needed in order to manage his care effectively. Some of the most common symptoms are discussed below.

Pain

Pain is a very common symptom and can affect 70–90 per cent of patients with advanced prostate cancer.13 Pain may be difficult to control: the European Pain in Cancer (EPIC) survey showed that 64 per cent of patients on prescribed analgesia felt that their analgesia was inadequate at times.14

If possible, oral analgesics should be used as first line. There will be occasions where this is impossible, for example if the patient is nil by mouth or too frail to manage oral medication, and in these cases the preferred route is subcutaneous. It is important to remember that if a patient is taking regular, oral opioids, he will need to be converted to a subcutaneous route, usually via a syringe driver, when he is no longer able to swallow.

The principles of the World Health Organization analgesic ladder should be used when prescribing. NICE has also published guidelines on the use of opioids in palliative care, which specify that morphine sulphate should be used as the first-line strong opioid whenever possible.15

The use of adjuvants with opioid-based analgesia is an effective way of managing pain and minimising the dose of opioids needed, thereby reducing side-effects. Adjuvants that may be considered include non-steroidal anti-inflammatory medication, corticosteroids and neuropathic pain medication, all of which have their own side-effects and contraindications.

Non-pharmacological techniques may also be useful in some patients: for example, the use of transcutaneous electrical nerve stimulation.

Nausea and vomiting

Nausea and vomiting are common symptoms in advanced cancer. There are various causes and appropriate treatment is dependent on the cause. The aim is to remove or treat the cause as appropriate (Table 1). It is important to remember that bowel obstruction is also a cause of vomiting in advanced pelvic or abdominal disease. Therefore careful assessment and examination of the patient is vital and any sign of bowel obstruction should be treated appropriately.16,17

Agitation

Agitation at the end of life is common and can be distressing to relatives and clinical staff. It is important that reversible causes of agitation are looked for and treated appropriately. This may include urinary retention, constipation, pain and alcohol or nicotine withdrawal. Sedative medication should be used only if reversible...
PALLIATIVE CARE

CARE OF THE RELATIVES AND CARERS

Dame Ciceley Saunders, founder of the modern hospice movement, said 'How people die remains in the memory of those who live on'. A vital part of caring for dying patients is ensuring their families and carers are well supported. This is the responsibility of the clinical and nursing team as well as the wider multidisciplinary team. The VOICES survey focused on the experience of recently bereaved relatives and highlighted the needs of carers. Only half of carers felt they received as much support as they wanted during the last three months of the patient's life. The LCP also focuses on bereavement care after a patient has died.

CONCLUSION

The care of dying patients is a vital skill for every clinician. This care begins long before the patient is approaching the last few days of life. Skills such as advance care planning, involving the whole multidisciplinary team and supporting the family are as important as symptom control in the last few hours of life.

Declarations of interests: none declared.

REFERENCES


Table 1. Common causes and suggested treatment of nausea and vomiting

<table>
<thead>
<tr>
<th>Cause of nausea and vomiting</th>
<th>Suggested treatment</th>
</tr>
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<tbody>
<tr>
<td>Impaired gastric emptying</td>
<td>Metoclopramide or domperidone</td>
</tr>
<tr>
<td>Chemical induced, eg opioids, antibiotics</td>
<td>Haloperidol or levomepromazine</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Granisetron or metoclopramide</td>
</tr>
<tr>
<td>Metabolic, eg renal failure</td>
<td>Haloperidol or levomepromazine</td>
</tr>
<tr>
<td>Intracranial disease, eg brain metastases</td>
<td>Cyclizine and consider dexamethasone if there is possible raised intracranial pressure</td>
</tr>
<tr>
<td>Vestibular, ie movement related</td>
<td>Cyclizine or levomepromazine</td>
</tr>
<tr>
<td>Cause unclear</td>
<td>Haloperidol or cyclizine or levomepromazine</td>
</tr>
</tbody>
</table>

causes cannot be found or treated. The LCP suggests using midazolam subcutaneously to treat terminal agitation. Some patients may need a subcutaneous infusion of midazolam if their agitation is persistent.

Respiratory tract secretions

Some patients develop respiratory secretions when they are dying. It is generally accepted that this is unlikely to cause distress to the patient; however, relatives often find it upsetting. The LCP guidelines suggest it is treated with hyoscine hydrobromide subcutaneously, though local guidelines may use other anticholinergics.

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