

section 2.2: symptom management principles

management principles- an overview

In the setting of a life limiting illness, quality of life and excellent management of symptoms is crucial and remains a predominant concern for patients and for those family members who care for them. Palliative patients may require access to a range of non-curative interventions for which the primary aim is control of symptoms and improvement of quality of life. These include palliative chemotherapy and radiotherapy, pharmacological and non-pharmacological treatments, surgical and orthopaedic procedures and anaesthetic procedures for pain relief.¹ Palliative interventions may be targeted at alleviating the cause, while at other times they may focus on alleviating the effects of the symptom. These interventions can be implemented at any time during an illness.

Attention to detail is vital to providing physical relief; however, fears of loss of dignity, becoming a burden, and anxieties related to surviving family members may be greater than fear of pain or death itself. Patients with advanced illness report that existential issues of isolation, hopelessness and uncertainty occur as frequently as other physical and psychological symptoms² – allowing time for patients to voice these fears may provide the opportunity to address them realistically.³

Those symptoms most commonly experienced in the last year of life, listed in order of their incidence include:

- o breathlessness
- o fatigue and weakness
- o nausea
- o dry mouth
- o constipation
- o pruritis
- o pain
- o anorexia
- o constipation
- o cough
- o low mood⁴

Symptom management principles include:

Evaluation

- undertaking careful clinical assessment, with attention to detail
- using a scoring system which allows a sense of success in managing symptoms over time, or identifies the need to change management interventions - a visual analogue, numeric rating scale or verbal descriptor is suitable – see *Therapeutic Guidelines – Palliative Care*, Appendix 3
- exploring the characteristics of the symptoms, including intensity, location, quality, frequency, associated pattern of disability, meaning of the symptom to the person (personal beliefs and goals), behavioural responses (what is the person doing to manage or cope with the symptom), contributing or alleviating factors
- asking: how far has disease progressed?
- asking: what is the patient's functional status?
- asking: what is the likely cause of the symptom?
- asking: what is potentially reversible?

Communication

- explaining what has been discovered following assessment or investigations
- taking time to explore the goals of care for *this patient at this time and for this disease*
- ensuring responsibility for discussing the treatment options that are available (and what may not be technically possible or ethically offered) is taken by the most appropriate member of the treating team
- ensuring that all members of the team are communicating the same information ie “reading from the same page” to avoid confusion and frustration for patients and family

Individualized treatment planning

- taking into account the stage of the patient’s disease and the relative risks and benefits of interventions
- adopting a responsive approach, which is not changed unnecessarily but can be altered as circumstances change
- presenting plans in a positive manner with an explanation about the sharing of responsibilities within the team
- where possible interventions should be based on best available evidence at this time
- communicating changes to care plans to the patient and family, particularly if symptom is refractory to usual management

Monitoring of progress

- regularly reviewing symptom management is essential
- acknowledging that small improvements in symptoms may make a real difference in the quality of life for patients
- adjusting dosages of medications for weight loss and liver and renal impairment
- communicating frequently and clearly, particularly if the symptom is refractory to the usual treatments
- a fresh set of eyes can provide a valuable new perspective⁵ to a difficult clinical situation

Palliative emergencies such as hypercalcaemia, acute airways obstruction, spinal cord compression, superior vena cava obstruction, sudden and severe haemorrhage and uncontrolled pain require **immediate medical assessment and consideration for intervention**. – see *Therapeutic Guidelines – Palliative Care or Palliative Care Emergencies*, listed below.

Other complications of disease which may occur in palliative patients are pathological fractures and visceral obstruction – treatment options will be guided by the stage of disease, prognosis and the patient’s preference.⁶

related resources and information

Therapeutic Guidelines – Palliative Care

The management of symptoms previously mentioned and other symptoms relevant to palliative patients are specifically outlined in Therapeutic Guidelines – Palliative Care – see www.tg.com.au

In public hospitals these can be accessed via the Intranet.

Pain management

Pain management on line teaching resources at www.cancernursing.org

End of life/ Palliative Education Resource Centre (EPERC) see www.eperc.mcw.edu/
- EPERC fast facts about palliative care

Current learning in Palliative care (CLIP) – provide 15 minute online tutorials across levels of experience: <http://www.helpthehospices.org.uk/>
see Section 9- *additional information and resources*

CareSearch website offers additional resources, see www.caresearch.com.au

Palliative Care Emergencies

Emergencies in Palliative and Supportive Care (2006) Currow D, Clark K. Oxford University Press, Oxford.

Clinical practice guidelines for the psychosocial care of adults with cancer. National Breast Cancer Centre and the National Cancer Control Initiative, National Breast Cancer Centre, 2003.

references

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- ¹ Addington-Hall J, Higginson I (2001) *Palliative Care for non-cancer patients.* Oxford. Oxford University Press.
 - ² Morita T, Kawa M, Honke Y et al (2004) Existential concerns of terminally ill cancer patients receiving specialised palliative care in Japan. *Supportive care in Cancer.*12:137-140.
 - ³ Brooksbank M (2004) Guidelines to symptom control in Palliative Care, Central and Eastern Adelaide Palliative Care Service.
 - ⁴ von Gunten, CF (2005) Interventions to manage symptoms at the end of life. *Journal of Palliative Medicine* (8 suppl) 88-94.
 - ⁵ Christakis; Lamont, E. (2000) Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study *British Medical Journal*, 2000; 320 469- 473.
 - ⁶ Woodruff R (2004) *Palliative Medicine; Evidence- based symptomatic and supportive care for patients with advanced cancer.* Oxford University Press, Oxford.