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EDITORIAL

Benefits and burdens in palliative care

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In the last decade the development of palliative care and palliative medicine has brought much benefit for patients, their families and health care professionals. Maintaining and improving quality of life as well as sufficient alleviation of patients symptoms and complaints remain the main overall objectives. Achieving these provide to patients important feelings of confidence and comfort which is the basis for them to feel secure in their otherwise uncertain situation. An open, transparent and respectful relation of caregivers, along with others involved in palliative process, with the patient and his direct surrounding is needed to accomplish these objectives. This relationship is always an evolving process and should lead to a basis level of understanding and common interest. Within this level of understanding patient and family (as well as other close ones) can understand the palliative care process, including decision making, and also contribute themselves in this process.

To achieve this result caregivers have to understand that this task is multiple: providing adequate somatic support and relief but also psychological and social empathy together with professional attitude that functions through an open and respectful communication. Besides, it may and sometimes has to include giving guidance in difficult and emotional times for patient and his direct surrounding. All of the above mentioned may be difficult to achieve but also it may have a very natural and smooth course. In any case, if achieved, it will give the most rewarding fulfillment of the task of caregivers.

This issue of PALIATIA shows both ultimate sides of palliative care : the burden and benefit it may offer. The burden includes intensity and never changing end of the palliative care process and hereby its impact on families and formal and informal caregivers. This intensity makes palliative care not easy. The burden is also caused by enormous requirements for an individual caregiver as well as for palliative care team: coping with dying and death, understanding and controlling the pathophysiology of disease, and treating complaints along the process of dying, adequate signaling and discovering of somatic and psychological symptoms of palliative problems but also delivering shared decision making, open communication, making balanced choices. In itself these requirements are not part of 'everyday life', nor work in a average health care institution or office. Yet, in the case of palliative care situation they have to be part of an armitory of almost every caregiver actively involved in palliative care. Literally, it means that the caregiver in palliative care is expected or even sometimes required to be a perfect expert with fulltime availability.

Understandingly in most of the cases it is the palliative care team that is responsible for the required performance in delivering of palliative care. A solution that is most obvious since measures and tools required need multidisciplinary approach. This ofcourse brings another dimension for the caregivers to cope with: cooperation in the palliative care team without conflicting patient interest with, for example, competition for patients' confidence. This aspect is mostly not recognised as a problem but can through differences in communication and approach to the patient and his family sometimes raise unwanted misunderstandings. Above mentioned requirements does not mean that we need super human beings as (formal and informal) palliative caregivers. Like patients and their family caregivers are just men as all. But they are those who have chosen to help other human beings during the palliative

stage at the end of life. Here fore, they have to carry responsibility to perform humanly, professionally, and adequately. Additionally, they need continuously to educate and train themselves for this multipurpose task. In final, when together with the patient and his beloved ones mutual goals are achieved, the result is professional and personal fulfillment. A feeling unique for mankind.

ORIGINAL PAPERS

The communication of bad news in oncology

3. The efficacy of the cognitive-behavioural psychotherapy in the treatment of depression in patients suffering of oncological diseases in terminal stages

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Abstract

Objectives:

This study deals with the efficacy of the cognitive-behavioural psychotherapy in the treatment of depressive symptoms in terminally ill cancer patients. Specific objectives are:

1. to describe the practical ways in which patients are assisted;
2. to classify the types of psycho-therapies used;
3. to analyse the efficacy of the cognitive-behavioural psychotherapy when treating depression in cancer patients in the terminal stages of the disease.

Methods:

This study is based on interviews and observations in 110 cancer patients and 125 therapists (general practitioners, specialists in oncology, resident doctors in oncology, nurses, social assistants, psychologists).

The depression inventory of Aron Beck was used to assess depressive symptoms.

Results:

After attending the sessions of psychotherapy, cognitive-behavioral depressive symptoms decreased. Many patients changed their focus, giving attention to other issues not related to the disease. However, due to illness other problems remained unsolved such as: relational problems, professional possibilities after discharge, setting realistic goals with family, etc.. For women amputation of the breast or uterus created special coping problems.

Conclusions:

Cognitive-behavioural psychotherapy is an efficient way of treating the depression along with the pharmaceutical treatment in terminal ill cancer patients.

Key words: cognitive-behavioral psychotherapy, group therapy, Balint groups, depression, palliative care

(Full Text in Romanian)

The burnout syndrome in physicians working in palliative care settings for cancer patients: are physicians prepared to face?

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Abstract

The paper is a review about the burnout syndrome in physicians working in palliative care with cancer patients. It is the perspective of a medical oncologist who is working both in palliative care and in medical oncology with curative intention.

Objectives:

To describe the prevalence of the burnout syndrome in the target population: palliative care cancer specialists.

Methods:

The study investigates descriptive studies and reviews the literature; the target population is physicians working only in palliative cancer care. The review is based on English and Romanian papers, obtained for free from MEDLINE, EMBASE, CINHALL, SAGE, Psychinfo, SIGLE.

Results:

The selected articles show, that the studied population is partly affected by the palliative care work. The levels of psychiatric morbidity and burnout are not bigger than in other medical specialists but the distress levels are significantly higher. However, the Romanian articles show high prevalence of burnout syndrome compared with studies in other countries.

Conclusions:

The prevalence of burnout syndrome in physicians working in palliative care settings with cancer patients is not very high as compared to other medical professionals. More research is needed to understand the factors that are related to the burnout syndrome, especially among physicians working with cancer patients. The manifestation of burnout syndrome may strongly be influenced by the work conditions (culture, infrastructure). In Romania palliative care is a relatively new medical branch so not everyone that is caring for cancer patients knows the risks and the protective methods facing with this syndrome.

Key words: *burnout, palliative medicine, oncologist*

(Full text in Romanian)

CLINICAL LESSONS

Management of asthenia in palliative care patients

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Abstract

Asthenia, a symptom characterized by a general lack of energy and strength, exhaustion after a long period of stress, related or not to the illness, is one of the most frequent symptoms in healthy people and in palliative care patients. For (terminal ill) patients the question is analysed what treatment is available to overcome asthenia.

The incidence of asthenia is 10% in the healthy population, between 80% and 90% in patients who need palliative care and approximately 90% for patients at the end of their lives. Very often, asthenia is underestimated and considered by the medical team, patients and their relatives as a normal consequence of the disease.

Asthenia does not seem to be related to race, age, sex, wealth, level of education or the geographical area.

Asthenia can be treated with medication and/or with alternative methods such as meditation, music therapy, homeopathy, acupuncture or massage therapy. Treatment of asthenia in patients at the end of life is not always indicated. Side effects may cause more pain for the patient and frustration for the medical team and relatives.

Asthenia is not normal and therefore a standard question to the patient should be: „Do you feel tired?”. However, the indication to treat patients is difficult because of the side effects which are related to the treatment. More research is needed to find an effective treatment for these patients.

Key words: *asthenia, palliative care, management, complementary therapies*

(Full text in Romanian)

Palliative care in a case of late-detected lung cancer

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Abstract

Lung cancer is one of the most common and serious malignant tumors, representing over 90% of lung tumors. This cancer is the most common malignant cause of death in Europe as well as in Romania. The (early) detection of lung cancer is still a major problem in Romania; two thirds of the cases cannot be treated at the moment of diagnosis.

We present a patient, 72 years, male, ex-smoker, diagnosed late with lung cancer, stage III to IV without any shown symptoms of this cancer.

The evolution of this case was extremely fast and progressive after the diagnosis; the patient died two weeks after the diagnosis. The first symptoms were of neurological nature, making diagnosis uncertain. The treating physician recommended only palliative care as the only alternative to maintain quality of life.

The patient received palliative care in the family, continued care in an intensive care unit with a palliative care team. The patient himself had worked in health care and was well aware of the prognosis of this disease. The main activity was focused on psychological counseling by the team besides symptom management (fatigue, dizziness, fever, pareses, constipation).

This case clearly highlights the need for early detection of lung cancer, but also the need for palliative care services for cases that cannot benefit from curative treatment.

Key words: lung cancer, symptom management, palliative care, quality of life, prognosis.

(Full text in Romanian)

MANAGEMENT

Palliative care: a new solution to an old-age problem with personal reflections

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Abstract

In the late 60's of the last century, the concept of palliative care was initiated for hospice care for those persons with incurable cancer who needed an integrated treatment plan for the easing of their suffering. It was noticed over the years, that also a person at the end-of-life with non-cancer diseases such as cirrhosis, severe respiratory illness and end-stage congestive heart failure needs this integrated multidisciplinary team approach and from this arose the concept of non-hospice palliative care.

Within Israel, the concept of hospice care for terminally ill cancer patients was incorporated into the medical system especially in the community. However the concept of non-hospice care for terminally ill persons was not apparent to medical staff and other professionals in acute care settings. Recently the Director General of the Ministry of Health of Israel put out a circular insisting on the introduction of palliative care units within the acute care hospital system.

This paper describes the formation of such a unit and the first cases treated by the palliative unit in the hospital. The authors provide their reflections on such a service and further recommendations for the future.

Key words: *palliative care, acute care setting, symptom control, pain relief*

Palliative care

The population of the world is living longer and often with more limitations in their activities of daily living. In order to ensure that patients will have this extended life span, modern medicine has increased in leaps and bounds in the area of medical technology and the "technocrats" are ruling the medical guidelines. However, at the end-of-life, the answers may not entirely rely on medical technology but also on the providing care with dignity and allowing the autonomy of the elderly to make their own decisions. Often this may be a new approach to an ancient problem. This requires a shift from curative and life prolonging care occurs towards a relief of suffering while maintaining the patient's dignity (1).

Medicine today has become a science but the "art" of medicine will eventually still rely on the compassion, the empathy and the uniqueness of human behavior of the health career when we start to deal with end-of-life issues (2). Once a patient has arrived at this stage, it is often accompanied by suffering, both on an emotional and a physical level. The medical team of physicians, nurses, and para-medical personell have to learn and be educated in relieving this suffering (3).

In the early 20th Century, it became clear that there was a need to develop care of patients suffering from discomfort as a result of diagnosed with incurable cancer. The concept of hospice care was started in Western World and over the years the wording was changed to palliative care – relief of suffering. The modern concept of palliative care started with the opening of St. Christopher's Hospice, England in the year 1967 (4). However many of those with incurable diseases such as end-stage heart failure, end-stage renal failure, end-stage respiratory disease were still getting active treatment in order to prevent their early demise, but were "suffering". Out of this quagmire of suffering came the need for a newer and broader concept of palliative care, i.e. non-hospice palliative care (5,6).

In many countries throughout Europe and Northern America this extension was a natural extension of already existing hospice-palliative teams in hospital, but for Israel the concept has become a new challenge to this old-age problem. Hospice palliative care wards are in existence in some acute tertiary care hospitals in Israel but the Ministry of Health has deemed the need to increase the awareness of non-hospice palliative care in acute tertiary care centers. The idea being the introduction of non-hospice palliative care to the general medical wards especially internal medicine wards.

It has been stated that the quality of care given in a tertiary care hospital will be based on the palliative care it provides (7). In the more developed countries, we seem to have reached the peak of our resources. Medical technology is increasing and costing more and more all the time and yet the resources are getting less and less. We cannot "cure" all of our patients but we can provide compassionate care to all.

Palliative care unit in a tertiary care hospital in Israel

As stated, there is a need for non-hospice palliative care units in every acute care setting. Our unit will be hospital-based and function on three different levels. It will provide palliative care and support for the patient and families, at the same time it will be involved in educating health care professionals in palliative care and finally it acts as a liaison between the hospital and the community. Within Israel, there exists a strong home-care hospice team which, due to the ever increasing needs, has become a palliative care unit, both hospice and non-hospice.

First Level:

Once a patient is identified (as early as possible) as needing relief of their suffering by providing appropriate palliative care, a multidisciplinary meeting will be set up including both the unit personnel, ward social worker, ward physician and nurse and especially the patient and his family. One needs to set out clear aims for all involved before any decisions are made for the patient and over and above to ensure the dignity of the patient is preserved. Follow-up visits by palliative unit personnel will be performed regularly to ensure that the recommendations are carried out according to the patient's wishes.

Second Level:

No new program can result in changes if there is no on-going educational program for the staff of the ward where the patient is admitted. The needs and desires of the patient are constantly changing and one needs to heighten the awareness of the ward staff to the patient's and family's needs. Staffs not trained in awareness of care with dignity, allowing autonomy and finally provide care with compassion, will in the end place barriers to the care of the patient at end-of-life.

Final Level:

Nowadays, hospital administrators measure the success or failure of their hospitals in terms of the turnover and funding by governmental agencies. The problem of "revolving-door" syndrome is well known. In the modern world, the average number of days of admission to a internal medicine ward is 4-5 days which may increase up to a week in these very sick elderly persons. If there is no continuum of care on all levels with a discharge plan to the

community, they will return with a very short time, even within a few hours of the same day of discharge.

Palliative care in a modern context

To narrow the gap of alienation between medical technology and the actual process of caring, one needs to have this new approach. Often one hears from our patients that under no circumstance they do want to be sent to the hospital to have their suffering extended and their dignity destroyed with intravenous lines, nasogastric tube feeding, catheters, monitors with alarms sounding all the time, repeated blood tests of little significance and especially loss of their autonomy.

Part of the challenge of the medical staff is to allow the patient to enter into the role of dying and to remove the death-denying culture so prevalent in the Western culture of today (2). We present our experience in introducing palliative care to acute care internal medicine wards.

Experience from the initial pilot consultations

The team was asked to consult the following patients in a general internal medicine ward. The first patient, male aged 59, was admitted to the ward for fever but was known to suffer from squamous cell carcinoma of parotid gland and had undergone radical surgery. The palliative team was able to relieve the symptoms which had affected his quality of life: dryness of mouth treated with sucking sweets, difficulty in swallowing of liquids to be treated with fluids by means of jelly, dyspnoea eased by ensuring that oxygen is always provided, loss of appetite treated with 160mg of megestrol, local infiltration of the cancer by preventing superimposed infection with the use of a local antibiotic and relief of intolerable pain by increasing analgetic dosage of dipyron to 3gram per day and addition of non-steroidal anti-inflammatory drug. All these "mild" symptoms were causing him suffering and a loss of quality of life and function and by these minor changes the patient reported feeling less suffering and the family were given means to receive continuing home palliative care at time of discharge.

The next patient consulted by the team was a 45 year old woman with metastatic carcinoma of the breast. She was complaining of discomfort and pain in the area of the drainage tube into the chest and application of local anesthetic eased her suffering. She had breakthrough pain and though was on fentanyl and oxycodone syrup 15mg as needed, the oxycodone dosage was inadequate to control her pain. The recommended dosage for breakthrough pain is 10% of the dosage of equivalent 250-300mg oxycodone and therefore the dosage was doubled with immediate relief of her pain. She was complaining of constipation and starting stool softener lactulose was recommended. Finally she was suffering from cough with dyspnoea related to the pleural effusions and a recommendation of using nebulized morphine was given. On follow-up the patient was feeling much better having her constipation relieved, her coughing was under control and she was pain free. The discharge plan included the introduction of the community palliative care unit to the family to continue her care at home.

The next patient seen by the team was a 51 year old man with bacterial peritonitis complicating cirrhosis and poorly differentiated carcinoma of lymph nodes. Once again pain was the major issue with inadequate dosage of narcotics and though on fentanyl the dosage of oxycodone for breakthrough pain but the dosage was increased to 30mg per day. As expected he was suffering from constipation and was given lactulose. Also recommended was the use of nystatin oral gel for glossitis, which would improve his eating. Finally he was put on megestrol 160mg daily. The patient had a tense abdomen from peritoneal effusion and had concomitant reflux with nausea. Metoclopramide was stopped since it increases peristaltic movements and he was given haloperidol in low dose of 1mg twice a day. On

follow-up the patient was now quiet and pain free. He had no vomiting or nausea and the family were grateful for the help.

The final patient was an 82 year old man with pancytopenia secondary to leukemia complicated by sepsis. The patient was in the final stages of his life and all treatment, except medication for pain, nausea and dyspnea in a 'cocktail', was stopped. Atropine to ease the 'death rattle' and promethazine for agitation were added to the regime of morphine, pethidine and haloperidol. Two days later the patient died and the family reported that during the last two nights, he was quiet and did not seem to be suffering, and they were grateful for the help he received from the team.

Personal reflections

All the patients had diseases which were incurable and yet they were receiving acute care with intensive follow-up including daily blood tests, radio-imaging, consultations and in the end they were all suffering. Palliative care is not ceasing of care but changing the direction of care, with a different emphasis. Symptoms need to be addressed and treated and though the medical staff was aware of the need for pain medication, the dosages of the medications were often inadequate to alleviate the suffering.

The palliative team is able to offer easing of the suffering and improving quality of life, by relief of not only pain but other accompanying symptoms.

The need for intervention on all levels was evident to all the staff of the palliative unit and the ward staff as well. Our impressions, confirmed the findings in study carried out in Israel by Ben Natan and colleagues (8) where it was shown that the most important need to be addressed is relief of pain, but also to improve dyspnoea, receive adequate nursing care, a listening-ear and above all dignity in care. This can only be realized by educating the medical staff about the approach to non-hospice and hospice palliative care. In a study by Bradley and her colleagues (9), it was suggested that by educating physician in palliative care, they may be influenced to refer to palliative care.

A result of the initial intervention program of our palliative unit has been the request from the internal medicine department to give a talk on the concept of non-hospice palliative care to all the doctors in the department. We all have to start somewhere.

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Nasal Fentanyl against breathlessness in ambulant palliative care?

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Abstract

Severe dyspnoea is the most threatening symptom of the dying and one of the main reasons for undesirable hospitalisation in end of life. Especially in home care there is a need for a non invasive, safe and highly effective method for symptom control. There are objective criteria for this common symptom but general accepted recommendations are missing. Frequently and in spite of the facts a widespread therapy of first choice is the application of oxygen. Even in home care oxygen is more and more common in end of life care. Solid facts for the pros and cons are discussed in this paper and alternative symptom control is shown for a highly effective and non invasive cure of the symptom breathlessness if the disease itself cannot be treated any more.

Fentanyl is an appropriate drug because of its fast onset and short duration of action. Since 2003 the Palliative Net Easthessia and Palliative Care Network Witten medicated more than 500 home care patients with nasal Fentanyl (naF). The method is simple, the user should have in mind the substance is highly effective. Both physician and pharmacist should inform themselves adequately before the first use about the basics of the manufacturing and use.

Clinical experience indicates that intranasal administration against dyspnoea is not inferior to the intravenous symptom control. In ambulant care non invasion is of great advantage and maybe applied by caring relatives or the patient himself. Prospective studies are needed to show the effectiveness of this method.

Key words: *breathlessness, palliative care, nasal fentanyl, dyspnoea*

Introduction

Acute breathlessness is a common and severe symptom in end-of-life-care of patients with progressive malignant diseases as well as cardiac failure, lung diseases, and neurological diseases. There is a good evidence for the use of opioids for symptom control (1), in spite of this the application of nebulized opioids is discussed controversy (2, 3). To choose the ideal medication the application and the time of onset are essential.

The ideal medication against breathlessness should be:

- easy to use (for patient and (in)formal care givers);
- short time onset (to control life threatening symptom);
- available under every possible condition (hospice, home, street).

Now the gold standard of symptom control of breathlessness in palliative care is morphine intravenous (4), nebulized and transmucosal. Fentanyl should be acceptable for symptom control but its evidence is limited so far (5, 6).

In Germany, availability of Fentanyl is regulated by the Neue Rezeptur Formularium (7). The use of it with the indication pain is allowed all over the world. The indication „symptom control

of breathlessness“ is nowhere in Europe allowed. So, symptom control of breathlessness even in the face of death is an „off-label-therapy“ all the time!

In 2007 and 2008 there had been some studies published which showed that intravenous morphine equals or is better than the use of tranquilizers (8), bronchospasmolytics (9) or oxygen (10) for symptom control of breathlessness. Intravenous application is highly effective but difficult to use in home care and it might cause problems because of the risk (application, complications). So transfer to a clinic occurs frequently if a patient suffers severe breathlessness (11).

The oral use of morphine or opioids is much less effective because of the longer time of onset compared with an iv (12). There are very few publications about nebulized opioids for symptom control (2). Until now the use of naF in ambulant setting has been published only by our teams (3). Since 2003 we have medicated over 500 patients at home with nasal Fentanyl (naF). We report here our clinical experience based on the treatment of these patients.

Physiological regulation for breathing

Since long time we know that a slight increase of carbon dioxide will cause a strong increase of the minute ventilation volume but for hypoxic air this reaction does occur much less. Everybody knows the dramatic breathlessness one feels if one chokes. An easy test is to keep breath whilst measuring oxygen saturation. Most untrained men will keep on breathing before the saturation decreases a single percent. A very small increase in carbon dioxide is enough to force breathing again.

Severe hypoxia may also cause breathlessness but only with very low levels of oxygen saturation. Very rarely our patients with breathlessness have oxygen saturation below 80% (2 out of 72 in III/IV 2009), so hypoxia usually does not cause breathlessness in our patients.

Pathophysiological facts are against the treatment with oxygen

Around oxygen there are a lot of myths. In emergency care the accepted ‘first-line’ treatment is: „never, never, never withhold oxygen therapy from any patient in respiratory distress“ (13), because only with oxygen an improvement of physiological parameters in emergency medicine can be seen at once. For emergency treatment of acute ill patients there are nearly no contraindications for oxygen and – if the patient is supervised properly (!) no specific risk for the use. Consequently breathlessness should disappear by increasing oxygen saturation. So, many patients in end of life care were treated with oxygen for breathlessness.

Several papers have shown that breathlessness could not be improved by the use of oxygen (14, 15). A Cochrane review in 2009 (16) stated: „the effect of oxygen for terminal ill cancer patients and terminal heart failure has not been proven“.

In spite of that the use of oxygen is recommended in many textbook for palliative care (17). This does not fit to the modern pathophysiological aspects of breathlessness.

Dangers caused by oxygen

Besides the technical requirements of oxygen treatment that can hinder good care at home there are specific risks for the use of oxygen in end of life care. First dryness of nose and mouth get worse. The oxygen concentrators are noisy and disturbing. Application via a mask which is the most effective way is badly tolerated; nose ulcers may occur as a result (18). If cigarettes are smoked severe burns had been described (19) which even hastens the death of the patients.

Who should receive oxygen in end of life care?

Hypoxia causes vaso- and bronchoconstriction. The bronchoconstriction could aggravate breathlessness and an increase of carbon dioxide in the blood. The receptors in glomus caroticum and much more in the medulla oblongata reacts a bit sensitive to hypoxia but much less than to hyperkapnia. Especially under physical exercise hypoxia seems to be an independent factor to increase the subjective feeling of breathlessness at least amongst healthy volunteers (14). So, there might be situations possible when oxygen makes sense in end of life care of multimorbide old patients. Especially, if a disease with a diminished gas exchange rate in the lung occurs and causes straining symptoms. In those rare cases oxygen may treat symptoms of breathlessness up to some part in spite, that this could not been proven in many studies (17).

Best care concept symptom control against breathlessness?

First of all care givers have to be self confident, calm, not in a hurry. They have to avoid everything to frighten the patient even more than he is now. A good position may help (upright, with the arms on the table, support all muscle to ventilate); a cool airstream by open windows or a ventilator sedates the hunger for air a bit; open tight clothes, decrease room temperature. All this together will help for some part.

At home self confidence of the patient and the support (of the capability) of the patient and his family care givers play an important role too. Very effective non pharmacological treatments are physiotherapy for breathing, walking assistance, vibrating massage of the thorax, neuromuscular electrotherapy and education of the family (20).

Safety has to be given to the patient by background information, hints, emergency phone numbers; availability of 24/7-palliative care team (who to call, somebody to help quickly). If the family is frightened than the patient will keep on being breathless. So, it is important to take care of the family.

Depression of ventilation as therapy concept against breathlessness!

Morphine and other opioids are the gold standard medication for symptomatic treatment of breathlessness. Even if they are "off label" for breathlessness and „dyspnoea“ is described as a possible side effect of opioid therapy!

Regulation of the breath is adapted to the situation of the patient. The set value of the desaturation of Carbon dioxide has to be sufficient enough to prevent breathlessness. In the acute pain therapy depression of breath is a dangerous side effect (21), in symptom control of severe breathlessness it is best care! Ventilation can become more economical, frequency of breath decrease, breathing becomes more effective and oxygen saturation increases.

Case Report

A 79 years old patient comes to a intensive care unit because of severe breathlessness. Diagnosis: respiratory insufficiency caused by respiratory infection, COPD – GOLD III-IV, coronary heart failure, diabetes IDDM-2, hyperlipoproteinemia, arterial hypertension, chronic kidney insufficiency, peripheral arteriosclerosis IV.

The patient was analog-sedated and controlled ventilated. After several complication and resuscitations a BIPAP ventilation became possible. After six weeks and antibiotic treatment with elimination of the bacteria's weaning had been tried during nine more weeks, but it failed. Several times in the intensive care unit he had episodes of extreme breathlessness with coughs, which had been life-threatening every time. He refused to stay in hospital any longer and had no will to live longer.

With the help of the general practitioner, the palliative care team and a well-trained-nursing team he could go back home with the artificial ventilation and all technical equipment needed. Pain was treated well with relatively low dose transdermal fentanyl patch (25 µg/h). Against break-through-pain he received naF with 100 µg fentanyl citrate per 50 µl puff. The care givers had been instructed to spray one or two puffs with a lock out interval of five minutes in case of acute pain or breathlessness. With this therapy the intervals without artificial respiration became longer and longer. After three weeks he was respirated with BIPAP only at the nights when he was asleep. At the end of the fourth week he was decanulated and the tracheostoma was closed with a patch. He could live on for three more lucky weeks, than he got another infection and died at home with his family giving care to him as everybody had wished it.

Titration set

We developed an easy to handle titration set for use in ambulant care (22). A solution of 20 mg fentanyl citrate is dissolved in 2 ml NaCl 0.9% with preservative in a nasal spray device. In addition, it contains two bottles of dilution solutions which are marked with different colours. With this set the doctor can use three different concentrations of nasal fentanyl without any calculation just by mixing one of the two dilution solutions into the nasal spray bottle. And after this he fixes a patch of the new colour onto the surface of the nasal spray bottle. With this method the risk of confusion is minimalized, which is extremely important in end-of-life-care and life-threatening situations which need a quick and safe solution.

The future?

In ambulant care of terminally ill or palliative care patients non invasion is a great advantage, especially, if the care givers are no professionals. As mentioned, the method for threatening symptoms should be safe, easy-to-use and fast at the same time. The nasal application of strong opioids e.g. naF seems to become a possible new standard in the treatment.

The use of the described titration set seems to be a progress for use at home for patients, who had not had nasal opioids before.

The range of indications for naF is wide. It can be used as well for symptom control of breathlessness as for symptom control of break-through or end-of-dose-failure pain, pain in wound management, anxiety and all the other indications where an opioid could help. Prospective research is needed to study the effectiveness of naF in palliative care (at home).

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COMMENTS, DISCUSSION

Retirement of patients with cancer: some guidelines for the attending physician

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Abstract

Cancers represent the fourth cause of disability in Romania and the second cause of death after cardiovascular diseases, because many cases are detected late in stages III-IV.

Medical criteria are used for the evaluation of the patients with cancer both for disability (invalidity) and handicap. Most European countries have this type of criteria, medical or medico-social. They are based on International Classification of malignant neoplasm, TNM.

Social factors play a key role not only in the early diagnosis of this disease, but also in treatment, compliance, and the need for social insurance.

Key words: *cancer, disability, handicap, social factors*

(Full text in Romanian)

NEWS

Workshop on Dignity Therapy

The Manitoba Palliative Care Research Unit will organise a new Workshop on Dignity Therapy which will be held May 25-27, 2011 in Winnipeg, Canada.

This workshop will be of interest to:

- clinicians working with palliative care and/or geriatric patients who are in a key position to use Dignity Therapy;
- researchers who wish to include Dignity Therapy in the development of new research projects;
- health care administrators/nursing home administrators responsible for creating and operationalizing an approach to care that supports and affirms patient dignity and personhood.

Registration for the workshop will be limited to 40 participants and the final registration deadline will be April 21, 2011.

For further information and/or to request a registration package, please contact the organization at : mpcru@cancercare.mb.ca