Department of Radiotherapy, PGIMER

PGIMER CHANDIGARH

Palliative Care in Carcinoma Cervix

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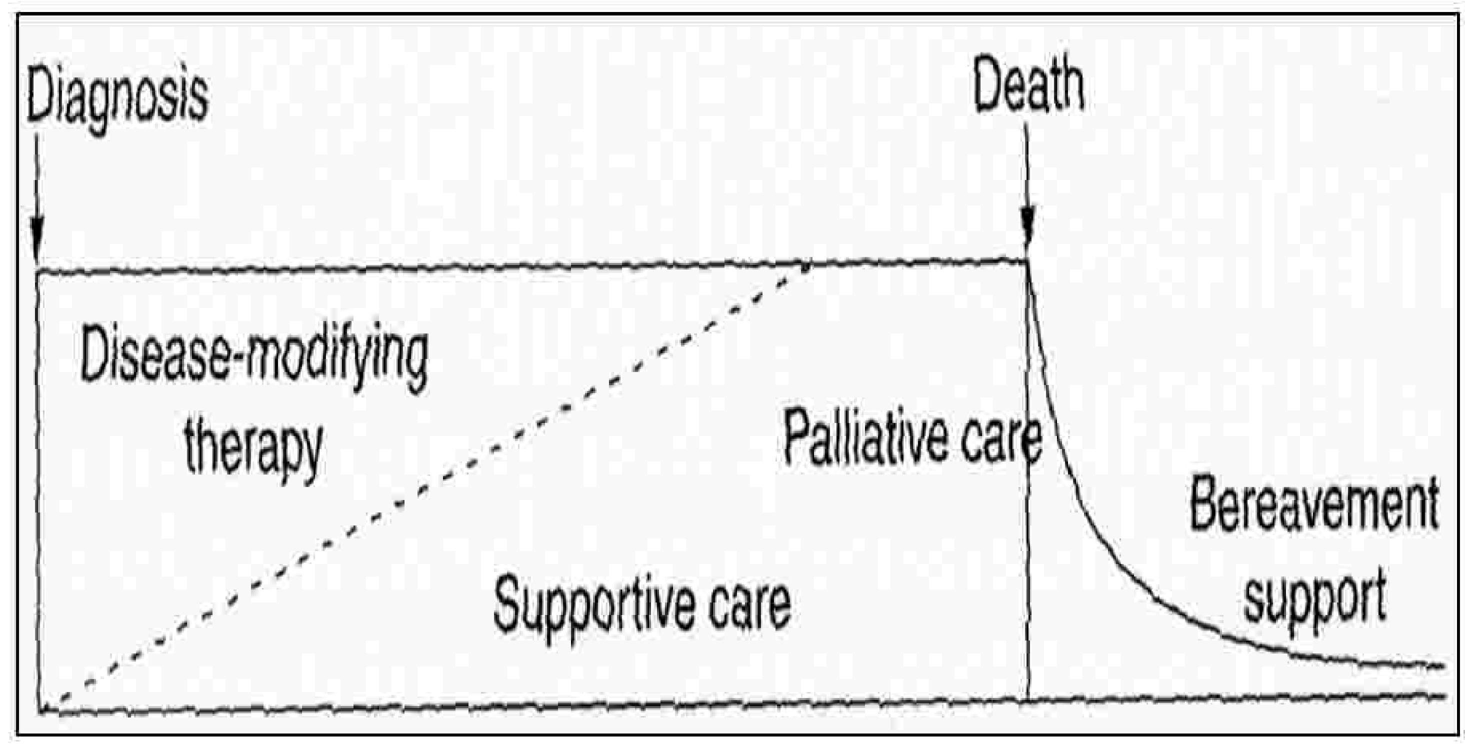
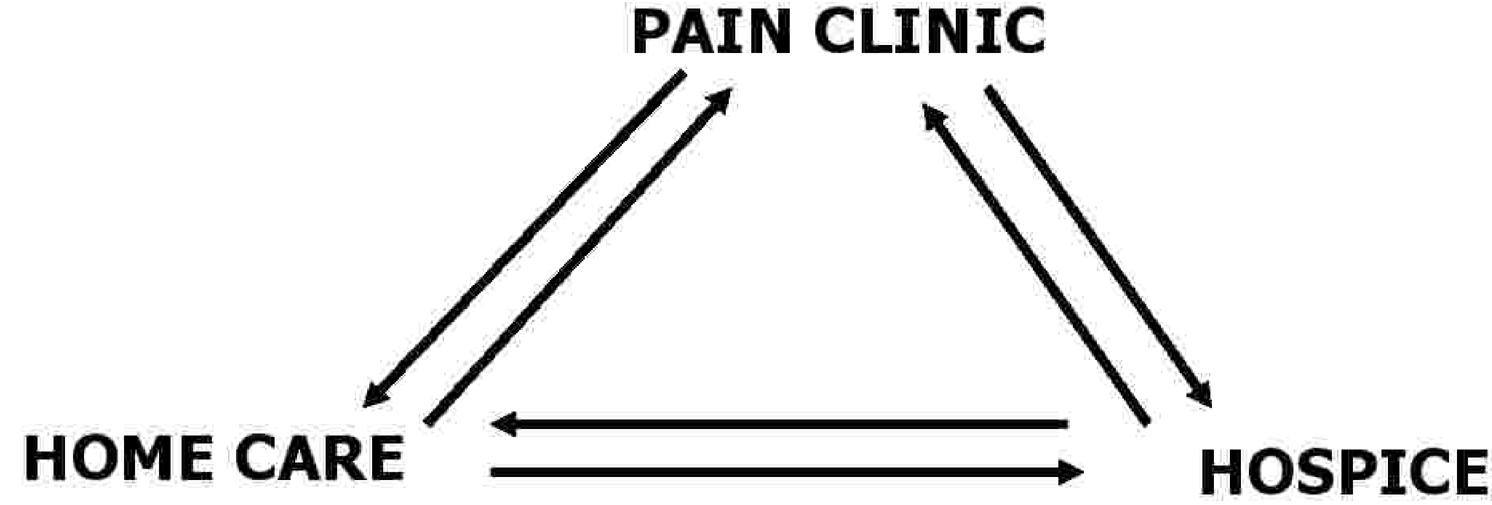
Palliative Care

- **Palliative Care**: active total control of patients whose disease is not responsive to curative treatment.
  - Requires control of **pain**, other symptoms, psychological, social and spiritual problems.
- **Goal**: Achievement of best possible quality of life for patients and their families.
- **WHEN**: Should be integrated with anticancer treatment and not be considered for terminally ill or end of life care.

Palliative Care

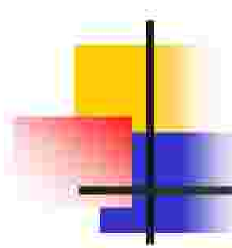

Diagnosis
Death
Disease-modifying therapy
Palliative care
Bereavement support
Supportive care

PGIMER


PAIN CLINIC
HOME CARE
HOSPICE

Hospital Palliative Care Service

Joint consultation between Oncologist & Palliative Care Doctor.



Home Care Service

February 2000 - Home care service with UT Red Cross.

- Team of doctor,nurse & social worker.

Hospice

PROBLEMS

Poor finances.

Lack of facilities

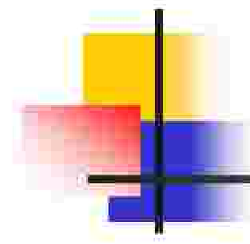
Acute care bed occupied

Resident may over treat

Hence need for Hospice

Chandigarh Hospice

Palliative Care



CHANGE OF FOCUS

FROM	TO
Disease oriented treatment.	Patient oriented treatment.
Patient alone.	Entire family.
Prolonging life at any cost.	Prolonging fruitful life. Not prolonging death.
Ethos of cure. (military virtues of fighting and never giving up)	Ethos of care. (has human dignity central value and effective compassion.)
Physician is the general.	Patient is the sovereign.

Physical Symptoms

Symptom	n	(%)
Pain	90	(96%)
Constipation	86	(92%)
Foul smelling discharge	20	(21%)
Burning Sensation	15	(16%)
Bleeding P/R	14	(15%)
Lymphedema	10	(10%)
Incontinence (VVF,RVF)	09	(09%)
Ascites	06	(6.5%)
Bleeding P/V	02	(02%)
Small bowel obstruction		

Pain

Pain is a more terrible lord of mankind than even death itself…

Pain

- It is an unpleasant sensory and emotional experience associated with acute or potential tissue damage or described in terms of such damage.

- Pain is always subjective

- Pain is what the patient says hurts, what the patient describes and not what others think it ought to be.

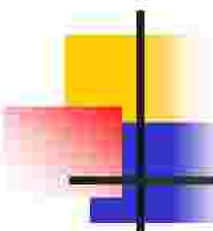
Mechanism of Pain

SOMATIC

- Stimulation of nociceptors in cutaneous or deep tissues
- Dull aching pain but well localized
- Metastatic bone pain, post surgical incisional pain, musculoskeletal pain

VISCERAL

- Stimulation of nociceptors from infiltration, compression or stretching of thoracic, abdominal or pelvic viscera
- Deep squeezing and pressure like, poorly localized
- Patients with intraperitoneal metastasis



Mechanism of Pain

- **NEUROPATHIC**

- injury to peripheral or CNS as a consequence of tumor compression or infiltration
- Severe pain, burning with a vice like quality
- Metastatic brachial plexopathy, postmastectomy pain

Pain in Carcinoma Cervix

- **Carcinomatous Plexopathy**

  Cardinal clinical feature Severe, unrelentless pain

  The local pain is pressure-like or aching in quality

  Referred pain varies with site of plexus involvement & can be burning, cramping or lancinating

- **Prevalence**

  Low plexopathy L4 – S1 commonest - 64%

  High plexopathy L1 - L3 - 28%

  Pan plexopathies - 8%

Pain in Carcinoma Cervix

- **Infiltration of upper plexus L1 to L4**

  Pain in the back, lower abdomen, flank, iliac crest or antero-lateral thigh.

- **Infiltration of lower plexus L4 to S1**

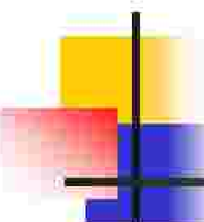
  Pain in the buttocks & perineum with referral to the posterior thigh.

- **Sacral plexopathy**

  Numbness of the medial dorsal foot & sole with associated weakness of knee flexion, ankle dorsiflexion & inversion

(R) (L)

(L) (R)



Measurement of Pain

1) Visual Analog Scale

No pain ———————————— worst pain

2) Numeric Scale

0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

(no pain) (worst pain)

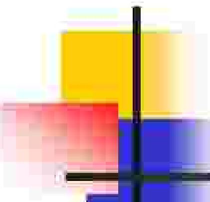
3) Verbal Descriptor Scale

mild moderate severe excruciating

4) Rupee Scale

Aims

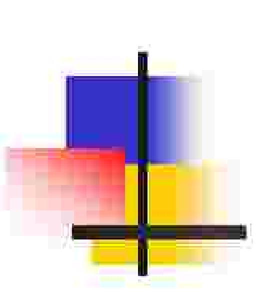
- Providing relief at night
- Relief at rest or during the day
- Relief on movement (if possible)

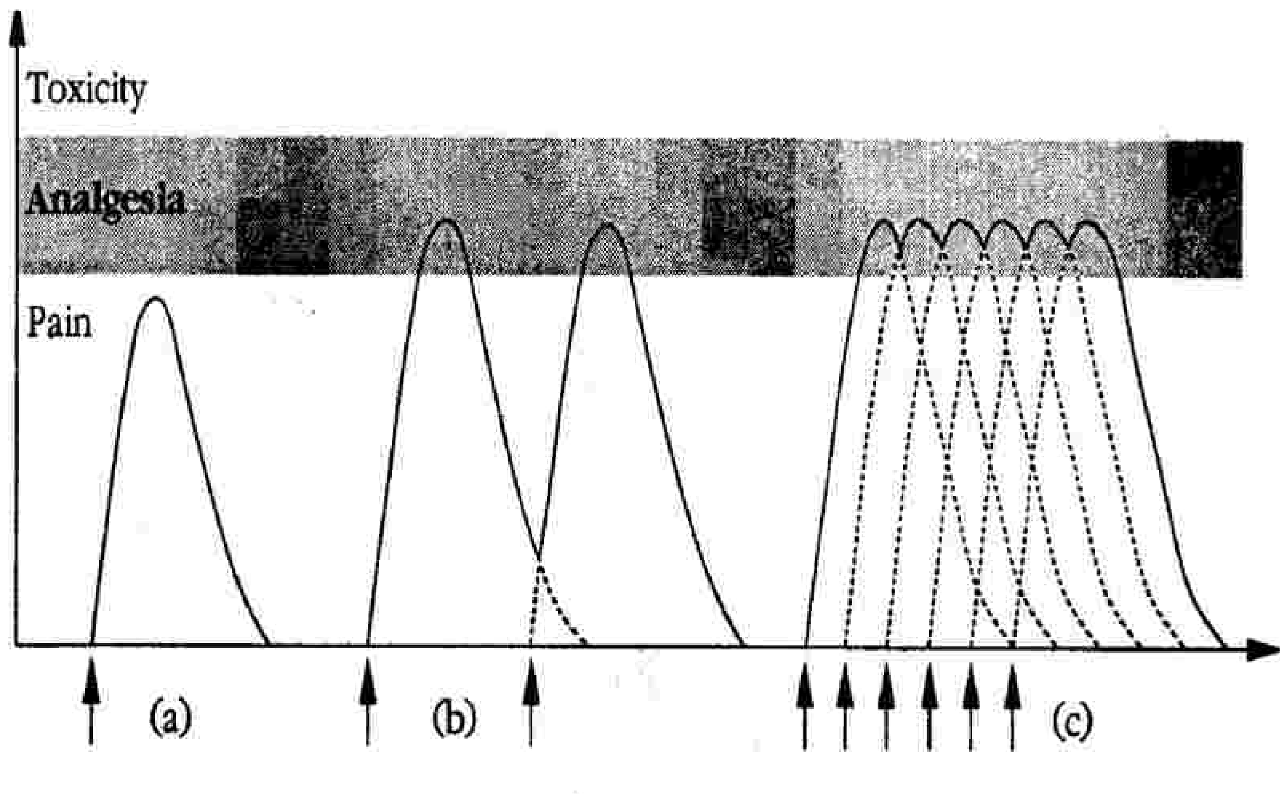


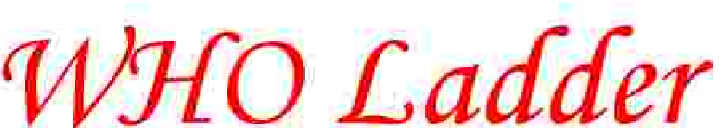
Treatment by Analgesics

- By the mouth
- By the clock
- By the ladder
- For the individual
- Monitor treatment
- Use adjuvant drugs

DRUG SCHEDULING







Freedom from Cancer Pain

Strong Opioid
+Non-opioid
± Adjuvant

Step III

Weak Opioid
+Non-opioid
± Adjuvant

Step II

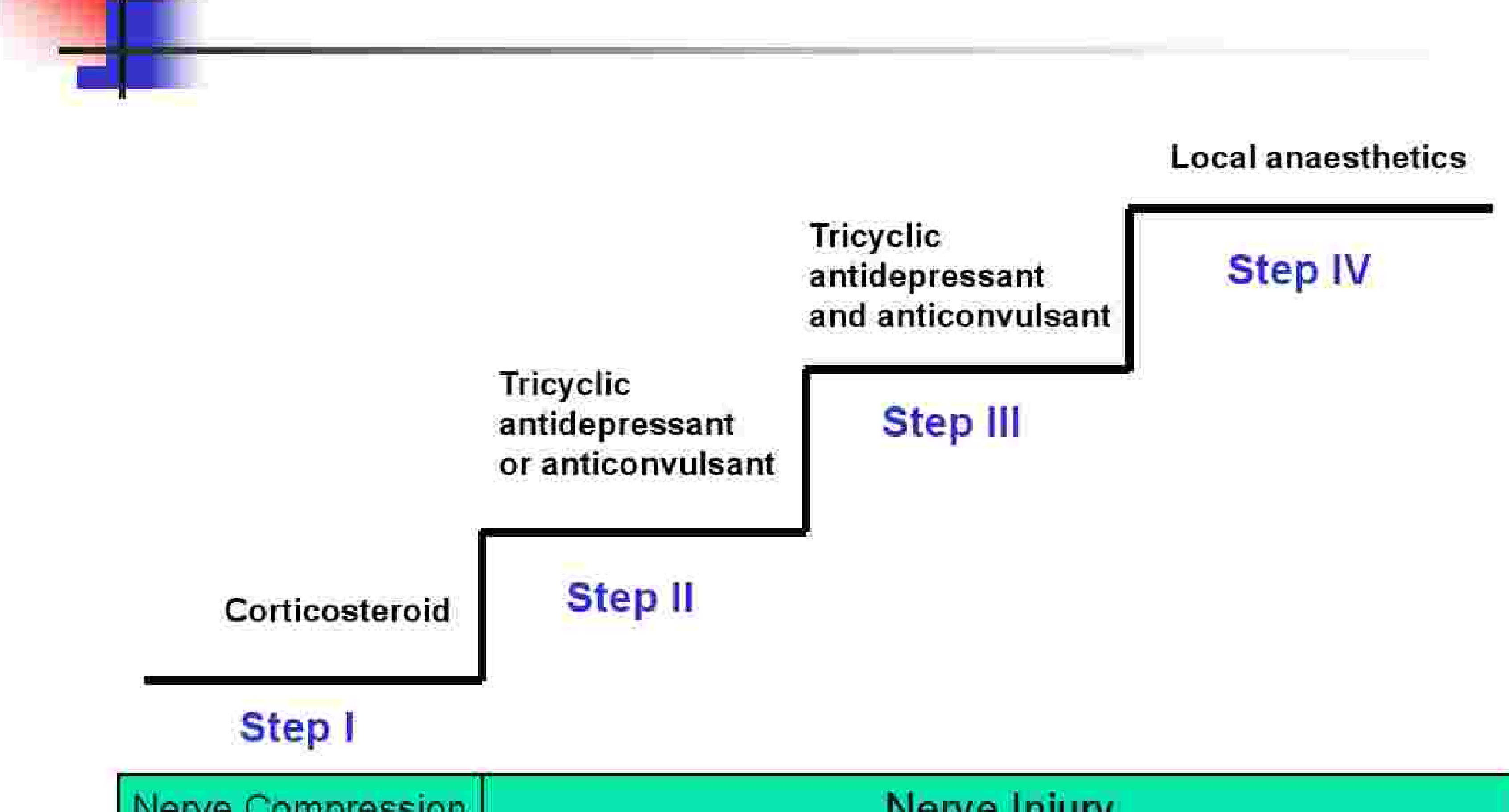
Non-opioid
± Adjuvant

Step I

Pain

W.H.O Three Step Analgesic Ladder

Neuropathic Pain



Drugs

- Non Opioids
  - Acetaminophen 500mg qid
  - NSAIDS –
  - Ibuprofen 400mg qid
  - Diclofenac 50-100mg bid
  - Aspirin
  - Naproxen 250-500mg bid

- Weak Opioids
  - Codeine
  - Dihydrocodeine
  - Dextropropoxyphene
  - Tramadol

- Strong Opioids
  - Morphine
  - Fentanyl
  - Diamorphine
  - Hydromorphine
  - Buprenorphine

Morphine

- Inexpensive and available in variety of dosage forms
- Most commonly used in the oral form
- Starting dose 10 mg 4hrly –Double Dose at night (7AM,11AM,3PM,7PM,11PM)
- If pain relief not satisfactory, increase by 50% of starting dose, breakthrough pain 1/6 of 24hr dose
- No maximum dose for morphine
- Side Effects
  - **Nausea and vomiting**: Use anti-emetics, alternative opioids
  - **Constipation**: Dulcolax 10-20mg, cremaffin 4tsf

Myths about Opioids

- Morphine does not cause **respiratory depression**
- **Pain** is physiological antagonist to central depressant effect of morphine
- **Psychological dependence** does not occur if morphine is used correctly
- **Sedation and drowsiness**: monitor KFT
- **Addiction**: Living your life for drugs
- **Medication**: Using drugs to live your life

Coanalgesics and Adjuvant drugs

- Corticosteroids: dexona 16mg→ 4-8mg OD
- Antidepressants: Amitriptyline 25-75mg
- Anticonvulsants: Gabapentin 100-600mg TDS, Carbamezipine, Valproate, phenytoin
- Anesthetics: Oral ketamine 10-25mg qid mixelitine

Bleeding

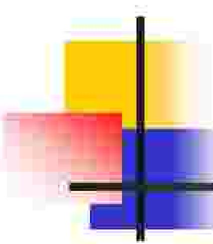
1. Directly from the tumor
2. Secondary to thrombocytopenia

- Pressure dressings or vaginal packing
- Hospitalization and bed rest
- Medication:

  tranexamic acid 500mg- 1gm q.i.d. or

  ethamsylate 500mg q.i.d.

  Topical adrenaline 1:1000 maybe used when dressings are changed
- Radiation: Hemostatic external RT or ICBT
- Arteriography: demonstrates the bleeding site
  - unilateral or bilateral internal iliac embolization.
  - Rarely, hypogastric ligation may be done if embolization fails



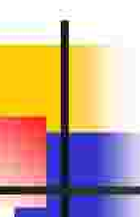
Malodourous Discharge

- Cleanliness/Hygiene

- Antibiotics :
  Systemic
  Topical - Metronidazole tablets 200mg crushed
  in KY jelly or 2% lignocaine jelly or betadine

  15gm Povidone Iodine – Rs.11
  1 tab. Metrogyl – 50 Paisa
  15 gm of 0.75% Metrogyl jelly – Rs.34

- Crushed Charcoal and honey



Obstructive Uropathy

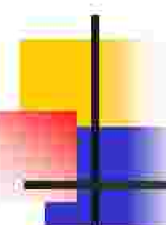
- Nearly two-thirds of patients with advanced disease, may lead to acute or chronic renal failure
- Relief of the ureteric obstruction by percutaneous nephrostomy (PCN)
- Advanced, disseminated disease allowing the patient to die with progressive uremia, maybe the least distressing course
- Haloperidol 1.5-5mg o.d..-t.d.s.. orally or 5-20mg/24 hr s.c. controls nausea, myoclonic jerks, confusion, and agitation.
- Morphine and other opioids should be used with longer dosing intervals, fentanylaccumulates less.

Incontinence (VVF/ RVF)

- Diapers
- Sterile pad with news-paper sheets
- Catheterization trial
- Ureteric stent/ bilateral nephrostomy drainage
- Diversion colostomy

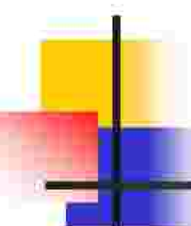
Lymphoedema

- Skin care: as it is prone to infections, skin supple and intact, avoid injury
- Movement: Normal movements/ gentle active or passive movements
- Exercise: stimulates the muscle pump, improves joint mobility, and improves posture and functional activities,promoting lymph drainage.
- External compression: daily application of multilayer, graduated compression bandages
- Manual lymphatic drainage(MLD): physiotherapist and taught to the patient or the attendant.



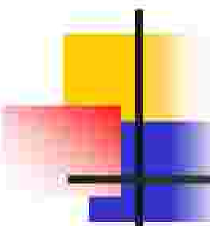
Bone Metastases

- Less common as compared to other malignancies
- MC involves the vertebral bodies secondary to nodal infiltration, pelvis and rarely the long bones
- Radiotherapy provides total pain relief in 50% patients and another 80-90% noting significant relief of symptoms
- Choosing between single fraction radiotherapy and a protracted course
- Protracted course may be considered in patients with a better prognosis, where bone strengthening, nerve compression or pathologic fractures is of main concern. Metastatic nodes infiltrating the vertebrae may require fractionated radiotherapy.



Other Medical Problems

- Anorexia & Cachexia
  - medroxyprogesterone acetate and megestrol acetate
  - low dose dexamethasone or intravenous methyl prednisolone
- Constipation
  - bedridden,decreased activity, diminished fluid intake, dehydration, hypercalcemia and low stool bulk. Neurologic and mechanical changes from presence of mass,opioids
- Nausea & Vomiting
  - Dehydration, electrolyte imbalance, neutropenia, renal sufficiency, drug or toxin induced,radiation therapy, metabolic, intestinal obstruction
  - Haloperidol, Ondansetron, granisetron, dexamethasone, metochlopromide, domperidone, antacids



Other Medical Problems

- **Intestinal Obstruction**
  - Surgical intervention is generally inappropriate
  - Symptomatic measures using medication are the mainstay
  - Nasogastric tube
- Malignant pleural effusion, parenchymal metastases and nodal/mediastinal metastases with airway compromise
  - oxygen, relief of bronchospasm, control of secretions
  - Thoracocentesis, chemical pleurodesis
- **Malignant Ascites**
  - Paracentesis, chemotherapy, diuretics, peritoneovenous shunts, no treatment

Other Problems

Psychological Problems

Anxiety, Depression, Fear
Feeling of worthlessness,
Being unwanted
Burden on family
Anticipation of misfortune.

Social Problems

Poor socio economic status (79%)
Stigma due to the disease
Fear of communicability
Social isolation

Ethical Problems

Artificial hydration
Relieving uremia
Do not tell patient

Conclusion

- Nearly 2/3 of cancer cervix patients need palliative management at some point of the disease course.
- Yet not much has been said and done for them.
- To cure sometimes, to relieve often and to comfort always.

Thank You