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

- Community Participation
- Continuity in Care
- To create a homely atmosphere
# Palliative Care

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
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<tbody>
<tr>
<td>Patient alone.</td>
<td>Entire family.</td>
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<tr>
<td>Ethos of cure. (military virtues of fighting and never giving up)</td>
<td>Ethos of care. (has human dignity central value and effective compassion.)</td>
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<tr>
<td>Physician is the <strong>general</strong>.</td>
<td>Patient is the <strong>sovereign</strong>.</td>
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<tr>
<td>Symptom</td>
<td>Count</td>
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<td>-------------------------------------</td>
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<tr>
<td>Pain</td>
<td>90</td>
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<tr>
<td>Constipation</td>
<td>86</td>
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<tr>
<td>Foul smelling discharge</td>
<td>20</td>
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<tr>
<td>Burning Sensation</td>
<td>15</td>
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<tr>
<td>Bleeding P/R</td>
<td>14</td>
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<tr>
<td>Lymphedema</td>
<td>10</td>
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<tr>
<td>Incontinence (VVF, RVF)</td>
<td>09</td>
</tr>
<tr>
<td>Ascites</td>
<td>06</td>
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<tr>
<td>Bleeding P/V</td>
<td>02</td>
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<tr>
<td>Small bowel obstruction</td>
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</table>
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.
Pain Assessment
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
WHO Ladder

Freedom from Cancer Pain

Strong Opioid + Non-opioid ± Adjuvant

Weak Opioid + Non-opioid ± Adjuvant

Non-opioid ± Adjuvant

Pain

Step I

Step II

Step III

W.H.O. Three Step Analgesic Ladder
Neuropathic Pain

Step I: Corticosteroid
Step II: Tricyclic antidepressant or anticonvulsant
Step III: Tricyclic antidepressant and anticonvulsant
Step IV: Local anaesthetics

Nerve Compression | Nerve Injury
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
  - Hydromorphone
  - 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, Carbamezpine, 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, fentanyl accumulates less.
Incontinence (VVF/ RVF)

- Diapers
- Sterile pad with newspaper 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, metochlopramide, 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.