Controlul simptomelor în contextul îngrijirilor paliative

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Proiectul Erasmus+ Parteneriate strategice - *Translating International Recommendations into Undergraduate Palliative Care Curriculum* (EDUPALL) - 2017-1-RO01-KA203-037382

- Dezvoltarea unui curriculum standardizat de îngrijiri paliative la nivel universitar, bazat pe recomandările Asociației Europene de Îngrijiri Paliative (EAPC)
- Formarea cadrelor didactice
- Pilotarea în 6 centre universitare

Recomandarile EAPC pt învățământ universitar

- 7 domenii
  - ✓Conceptul de îngrijiri paliative
  - ✓Durerea
  - ✓Managemntul altor simptome
  - ✓Aspecte psihosociale și spiritual
  - ✓Aspecte etice și legale
  - ✓Comunicare
  - ✓Munca în echipă și autoreflecție

Managementul constipatiei la pacientul adult din ingrijirea paliativa – curs studenti

Lesson Plan	
Teaching Unit	Symptom Management
Title	**Constipation/ Diarrhoea/ Nausea / Vomiting/ Anorexia, Cachexia, Fatigue/ Oral problems (Xerostomia, Dysphagia) Dyspnoea /Cough**
Learning Outcome (Link to EAPC Recommendation)	To asses and manage common symptoms palliative care using best evidence guidelines and protocols of care EAPC Recommendation 2. Pain and Symptom Management; (c) Symptom management - Gastrointestinal symptoms/ Anorexia, Cachexia and Fatigue/ Oral Care/ Pulmonary symptoms
Summary	Managing symptoms is a crucial part of palliative care. Palliative symptom management models highlight the need to ensure that symptom management interventions are targeted to the generating cause and concomitantly increase patient quality of life and comfort. A general principle of symptom management is to assess, plan, implement, monitor outcomes and include the patient and family in decision throughout the care. Gastrointestinal and respiratory symptoms are very common in palliative care. It is important to fully assess and consider all possible causes, including those which may require specific treatments.
Learning Objectives **A – Attitudes** **C- Cognition** **S - Skills**	**A – Attitudes** • Reflect on how each symptom affects the quality of life of the patient • Examine the limits of pharmacotherapy in relieving all/every symptom – and the doctors continued role in patient support. **C- Cognition** • Outline common causes of common symptoms, including: Constipation; Diarrhoea; Nausea; Vomiting; Anorexia; Cachexia; Fatigue; Oral problems (Xerostomia, Dysphagia); Dyspnoea; Cough. • Describe and justify management plans for uncomplicated symptoms, incorporating pharmacological and non-pharmacological approaches to care. **S - Skills** • Demonstrate the ability to provide education to people with life-limiting conditions, in the context of management of symptoms
Learning Methods	• Online training • Exercise: formative assessment • Case study

	• Experiential learning through bed side observation • Clinical discussion – Ward based bedside teaching • Case-based learning • Reflection on experience • Role play • Portfolio of learning
Timing	**E-learning / Distance Learning** 6 hours **Seminar** 2 hours • Case-based learning: focus to manage uncomplicated symptoms associated with life-limiting conditions using guidelines or protocols of care. Work in pairs: on a given case each pair develops a management plan using given guidelines/algorithms 15 min of care and presents it to review to whole group demonstrating also how they will provide education on their management plan to the patients 75 min (15 X 5) – **90 min** • Video with patients/ patient stories presenting impact of symptoms on their life and present management of the symptom – group reflection on impact of symptoms/ limits of pharmacotherapy in relieving all/every symptom – and the doctors continued role in patient support. **30 min**
Bibliography/Resources	1. Cherny, Nathan I., and Nicholas A. Christakis. Oxford textbook of palliative medicine. Oxford university press, 2011 2. Shah, Vishal, and Sachil Shah. "Management of Gastrointestinal Symptoms in Palliative Care." InnovAiT (2010). 3. North of England Cancer Network. (2016). Palliative and end of life care guidelines for cancer and non-cancer patients, 1 –33. Retrieved from http://www.necn.nhs.uk/wp-content/uploads/2016/09/NECNXPALLIATIVEXCAREX2016.pdf 4. https://www.nwcscnsenate.nhs.uk/files/5714/1503/5225/Guidelines_for_the_Medical_Management_of_Malignant_Bowel_Obstruction_Presentation_Draft_1.pdf?PDFPATHWAY=PDF 5. https://learningplatform.thepalliativehub.com/course/view.php?id=25
Assessment	1. MCQ 2. Short cases with Q/A 3. Reflect on how each symptom affects the quality of life of the patient (300 words)

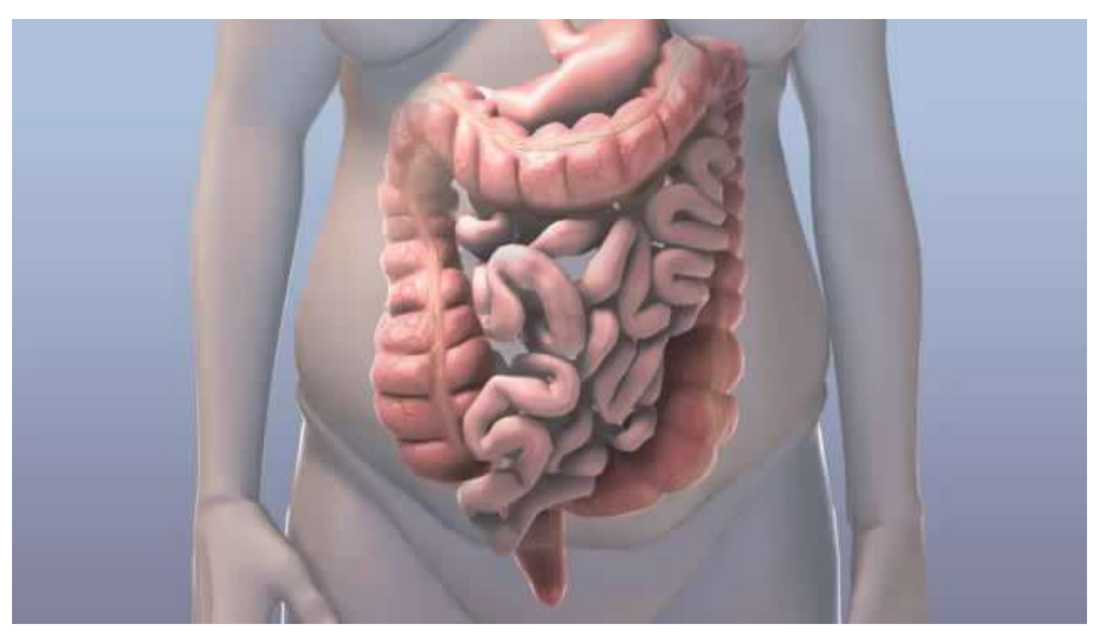
Ce este constipatia?

- Cum ati putea defini constipatia?
- Notati pe caietul dumneavoastra ce credeti ca este constipatia

For the purpose of this guideline, constipation is considered to be the infrequent (relative to a patient's normal bowel habit), difficult passage of small, hard faeces (44). However, the use of these criteria alone in defining constipation may fail to capture associated subjective symptoms which should also be taken into account. These include pain on defecation, flatulence, bloating, straining, unproductive urges or a sensation of incomplete evacuation (7, 17, 44). Although bowel frequency varies between individuals, if a patient is defecating less than three times per week, as used in the Rome III criteria for defining chronic constipation, assessment is recommended (17).

Level 5

Ce cauzeaza constipatia?



- Peristaltica prea lenta
- Prea multa apa absorbita din intestin

Sursa:

https://www.youtube.com/watch?v=ffD0A-P3qng

Table 2 Contributing factors to constipation in patients with advanced progressive illness
(Adapted with permission from Sykes* 2004 (44))

Organic Factors	
Pharmacological agents	Opioid analgesics, anti-cholinergics, antacids, anti-convulsants, anti-emetics, anti-tussives, anti-diarrhoeals, anti-parkinsonians, neuroleptics, anti-depressants, iron, diuretics, chemotherapeutic agents
Metabolic disturbances	Dehydration, hypercalcaemia, hypokalaemia, uraemia, hypothyroidism, diabetes mellitus
Weakness/fatigue	Proximal and central myopathy
Neurological disorders	Cerebral tumours, spinal cord impingement or infiltration, autonomic dysfunction
Structural abnormalities	Pelvic tumour mass, radiation fibrosis
Pain	Painful anorectal conditions, uncontrolled bone pain and other cancer pain
Functional Factors	
Diet	Anorexia, reduced food intake, poor fluid intake, low fibre diet
Environmental/cultural	Lack of privacy, comfort or assistance with toileting, cultural sensitivities regarding defecation
Other factors	Advanced age, inactivity, decreased mobility, depression, sedation

*Source: Oxford Textbook of Palliative Medicine 3E edited by Derek Doyle, Geoffrey Hanks, Nathan Cherny & Sir Kenneth Calman (2004) Ch. 8.3.3 "Constipation and diarrhoea" by Nigel Sykes pp. 483–496, Table 2 (p. 485) and Table 6 (p. 487) adapted. See www.oup.com

Evaluare pacient

- Pacienta 64 ani cu cancer de san si M1OSS se interneaza pentru durere osoasa pentru care ia de 3 saptamani Tramadol si Paracetamol.
- Asistenta de salon spune ca pacienta s-a plans de constipatie – nu a mai avut scaun de 1 saptamana si a intrebat-o daca ii poate da un supozitor.
- Medicatie de fond:
  - Tramadol
  - Paracetamol
  - Odansetron
  - Bifosfonati
  - Suplimente de calciu

Evaluare holistica - fizica, psihosociala si functionala

- Determina care este tiparul de functionare al intestinului
- Ce medicatie foloseste?
- Are anomalii structurale – mase tumorale pelvine?
- Fatigabilitate, slabiciune
- Durere
- Dieta
- Factori de mediu/ cultura
- Psihologici

Evaluare fizica

Inspectie

Distensia, peristaltica vizibila

Palpare

Fecaloame, mase tumorale, coarda colica

Ascultatie

Zgomote intestinale reduse, absente, borborisme

Evaluare severitate

BRISTOL STOOL CHART		
Type 1	Separate hard lumps	SEVERE CONSTIPATION
Type 2	Lumpy and sausage like	MILD CONSTIPATION
Type 3	A sausage shape with cracks in the surface	NORMAL
Type 4	Like a smooth, soft sausage or snake	NORMAL
Type 5	Soft blobs with clear-cut edges	LACKING FIBRE
Type 6	Mushy consistency with ragged edges	MILD DIARRHEA
Type 7	Liquid consistency with no solid pieces	SEVERE DIARRHEA

Tuseu rectal

- Componenta esentiala a evaluarii intestinale

As the normal state of the rectum is empty, the absence of faecal matter on DRE does not necessarily exclude constipation (52). One study found that 30% of patients with an empty rectum had faecal loading in the sigmoid colon on x-ray (53).	**Level 4**
Caution should be exercised in performing a DRE in thrombocytopaenic (Platelets <20 x 10^9/L) or immuno-compromised patients (52).	**Level 5**

Radiologie

Nu de rutina!

A PFA may be particularly useful in patients who cannot provide a reliable bowel history, for example, patients with cognitive impairment. It may also provide clarification in suspected "overflow diarrhoea" (57).	**Level 5**

Care sunt elementele esentiale ale evaluarii pacientului cu constipatie? (complement multiplu)

- □ istoricul
- □ examenul fizic
- □ radiografie abdominala pe gol
- □ radiografie abdominala cu substanta de contrast
- □ tuseu rectal

Key Finding A comprehensive assessment is required to accurately diagnose the presence and potential causes of constipation in patients with life-limiting illnesses.	
Key recommendations	
D	**1.1** A thorough history and physical examination are recommended as essential components of the assessment process.
D	**1.2** Constipation assessment scales may be useful in encouraging patient self-assessment or when communication is difficult. Due to a lack of evidence in the use of constipation assessment scales in day-to-day clinical practice they are **not** recommended for routine use.
D	**1.3** A digital rectal examination (DRE) should be considered to exclude faecal impaction if it has been more than 3 days since the last bowel movement or if the patient complains of incomplete evacuation (following appropriate DRE training).
D	**1.4** Caution is advised when considering a DRE in immuno-compromised or thrombocytopaenic patients.
D	**1.5** A plain film of the abdomen (PFA) is **not** recommended for routine evaluation but may be useful in combination with history and examination in certain patients.

Plan de management al constipatiei

1. PREVENTIE

2. Abordare farmacologica si non – farmacologica

3. Implicati toti membri echipei multidisciplinare
- Fatigabilitate – kinetoterapeut
- Functionalitate – infirmier, kinetoterapeut
- Nutritie – asistent medical, asistent de nutritie

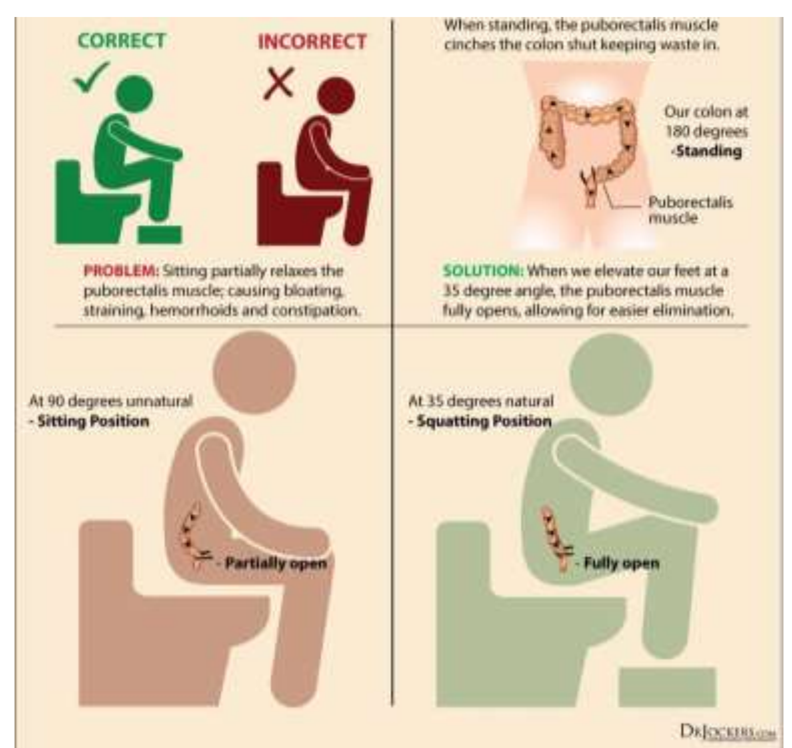
PREVENTIE

- Educare a pacientului asupra importantei masurilor farmacologice si non – farmacologice.

- Revizuirea medicatiei pentru a identifica potentialii agenti farmacologici care produc constipatie – prescriere medicatie profilactic

Non- Farmacologic

- Optimizarea strategiilor de “ toaleta”
- Aport adecvat de fluide si fibre
  (2l fluid/zi)
- Motivarea mobilizarii
- Masaj abdominal:



HIGH-FIBER FOODS THAT HELP YOU POOP

	Amount	Total Dietary Fiber (gm)
Prunes, dried	5 prunes	3.5
Orange	1 fruit	3.1
Apple w/ skin	1 large	5.4
Banana	1 large	3.5
Raspberries	1/2 cup	4.0
Lentils	1/2 cup	7.8
Almonds	1/4 cup	4.5
Cooked artichoke hearts	1/2 cup	7.2
100% bran cereal	1/2 cup	12.5

DIETvsDISEASE

- Ce interventii non-farmacologice considerati ca s-ar potrivi pacientei pe care ati avut-o de evaluat?

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Managementul farmacologic

Laxativele sunt interventia primara

Laxative predominant de inmuiere

Ispagula si metilceluloza = supliment de fibre
Polietilen glycol, macrogol
Lactuloza
Docusat
Senna
Bisacodil

Laxative predominant de stimulare

Puzzle

Ispagula si metilceluloza Actiune – dupa 10-24 ore Aport inadecvat de fluide conduce la obstructie mecanica Interfera cu absorbtia warfarin, aspirina, calcium Docusat – 1-3 zile	**Lubrefianti – ulei de parafina** Iritatie Scurgeri anale Granulom anal in folosirea cronica Reducerea absorbtiei de vitamin liposolubile Potential pneumonie de aspiratie
Senna , bisacodil , picosulfat Actiune - dupa 6-12 ore Pot da: • crampe abdominale • diaree • tulburari electrolitice **Laxative rectale** – clisma cu sodium citrate • Fecalom • Compresie medulara • Nu poate tolera laxative oral	**Macrogol** – folosit in tratarea constipatiei cronice 1-3 zile **Lactuloza –** fermenteaza in intestin si da balonare si flatulenta, frecvent diaree **1-2 zile** **Laxative saline – sare amara 15-30 min** • Interfera cu absorbtia altor medicamente prin cresterea ph gastric. (dat la 2-3 ore distanta de alte medicamente) • Iritatie locala, diaree

Laxative rectale – clisma cu sodium citrate

- Fecalom
- Compresie medulara
- Nu poate tolera laxative oral

Supozitor cu glicerina – 15-60 min

Bisacodil supozitoare – 15- 60 min stimulant, iritant

Constipatia produsa de opioide

- EAPC recomanda:
  - Reducerea dozei de opioid daca este posibil
  - Rotatia opioidului
  - Schimbarea caii de administrare
  - **Management simptomatic**

Opioide cu efecte advers constipatia - mai redus:

- Fentanil
- Metadona
- Tapentadol (PALEXIA) – μ- opioid agonist si inhibitor recaptare noradrenalina
- Oxicodona cu naloxona (TARGIN 5/2,5; 10/5; 20/10; 40/20)

- Echivalenta pentru rotatie: morfina/oxicodona+naloxone/tapentado= 20/10/50

Concluzii

- Constipatia necesita evaluare atenta a pacientului
- Interventiile vizeaza atat interventii farmacologice cat si non-farmacologice
- Nu uitati PREVENTIA

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