Ten Tops Tips - Palliative Care
Symptom Control

1. Make an accurate diagnosis.

Good palliative care is based on an accurate diagnosis of the cause of symptoms such as pain or vomiting. Don't fall into the trap of just treating the "cancer pain" with opiates, or the "cancer vomiting" without thinking of the cause.
Is the pain due to metastases which might need radiotherapy ?
Is the vomiting due to hypercalcaemia, gastric compression, UTI or drugs ?

2. Strive for excellent pain relief

Good pain relief requires regular dosing rather than a vague direction "as required".

Start cautiously, using 4-hourly morphine mixture, adjusting the dose to prevent pain breakthrough; once the dose is established consider swapping to a slow release preparation.

If pain is unrelieved (3 or more doses of breakthrough analgesia or reports of moderate or severe pain on three occasions over 24 hours) increase the baseline analgesia dose by 30-50%

3. Always prescribe for breakthrough pain

Calculate the doses accurately; for acute pain in someone already on an opiate, ordinary doses of diamorphine will do very little. The usual breakthrough dose is about 1/6th the daily total analgesic dose, so needs updating as analgesia requirements increase.

4. Plan for what might happen.

- Increased or new symptoms
- Inability to take oral medication
- Urinary retention
- Spinal cord compression

Give the patient and carer clear information (preferably in writing) about what to look out for and what to do. Ensure appropriate drugs are already prescribed – maybe in a Just in Case box - and equipment such as a syringe driver or urinary catheter pack is at the home or easily available.
Discuss with family and friends how to get care and help at different times. Specifically advise that calling 999 is very seldom appropriate and may result in resuscitation, transfer and admission.

Rehearse the final days and hours of life with family and carers, who may panic when terminal events take place. Try and prepare them for these. Consider using the excellent Liverpool Care Pathway booklet 'Coping with Dying – understanding the changes which occur before death.'
(available from http://www.mcpcil.org.uk/liverpool_care_pathway)

5. Breathlessness

Acute breathlessness is often accompanied by panic or fear. Sublingual lorazepam ('off-label' use) 0.5mg to 1mg can be quick and effective. For chronic breathlessness low-dose morphine, using a fan or opening the windows and simple relaxation exercises can help. Asking the patient to tell you about their fears may allow you to give reassurance (for instance that they will not choke to death).

Communication and organization of care

6. Ask about patients' wishes and record these as an anticipatory care plan

This allows people to exercise a degree of control and involvement in their care. Knowing that wishes about place of care and advanced decisions about resuscitation have been recorded and passed on is a great relief to many.

Ensure everyone involved in a patient's care knows of any care plans, highlight them in Practice records and communicate key points to those giving care out-of-hours in a handover form.

If you are seeing a patient you don't know – out-of-hours for instance – make an effort to find out about any advanced care plans etc and take note of these.

7. Try to establish open and clear communication with patient and family

Avoid giving exact prognoses – you will almost always be wrong! If a patient asks, you could hear what he or she thinks and then decide whether to correct any major misapprehensions. Talking in "days" "weeks" or "months" can give patients and families some indication but always remind them of the unreliability of even these predictions.

Don't make promises you can't keep – it is better to say 'we will do our best' than to make a promise that is not fulfilled.

Talk to patient and family together whenever possible. This helps discussion and means everyone is told the same thing. Consider joint visiting with the specialist palliative care nurse.

8. Be willing to ask difficult questions

Ask about patients' fears and concerns. "Are you frightened" can be a useful question that allows fears and anxieties to be discussed. Don't give empty reassurance "Don't worry" is dismissive and inappropriate for someone dying of cancer; it closes down the opportunity for someone to express deeper fears.

9. Be willing to ask for help

Specialist palliative care nurses and consultants will offer advice and help readily. In most areas this is available 24 hours a day. There is a good chapter on palliative prescribing in the BNF, there is now a section in MIMS and there are symptom control algorithms with the Liverpool care pathway and local guidelines too.

10. Work as a team.

Include the family and your local pharmacist in this. Share problems, support each other and review the care you have given. Don't forget to recognise when you have done a great job together. If things haven't all gone well think about how they could be better next time.

Complied by Macmillan GPs, Drs Prue Mitchell, Lucy Thompson, Angela Steele, Jonny Rae & Charles Campion-Smith. Published in PULSE, 28th April 2008.

Macmillan GPs are funded with protected time to produce recognisable improvements in the quality of cancer and palliative care provided by primary health care teams within the local health economy. For further information, please contact Macmillan's lead GP Advisor, Dr Rosie Loftus, rloftus@macmillan.org.uk