

The WHO definition of palliative care for children states that it begins when illness is diagnosed, and continues regardless of whether a child receives treatment directed at the disease.

South African palliative care practitioners, the Hospice Palliative Care Association and the Worldwide Palliative Care Alliance<sup>1</sup> endorse the WHO definition of palliative care and provide such care to patients with life-threatening illness from the time of referral to a hospice or a palliative care service. Hospice personnel frequently comment that patients are referred very late and do not experience the full benefit of the service.

There are a number of misconceptions with regard to palliative care that limit access to it. This article considers some of these and then describes how one can improve access to palliative care for those who need this approach.

Is palliative care only care of the dying patient? Palliative care practitioners and hospice personnel do provide quality, compassionate end-of-life care, with support for family members, to a person who is dying. Hospices also provide bereavement care to family members after the death of a loved one. However, palliative care personnel also support people in the active phase of their treatment. The focus of palliative care is on control of distressing symptoms, emotional support, social support and spiritual care with a goal of helping people with life-threatening illness 'to live as actively as possible'.

Is palliative care only compassionate companionship of dying patients? Palliative care is a clinical discipline involving careful assessment and active treatment of distressing symptoms, including identification and treatment of the cause of the symptoms. It aims to relieve suffering, and the response to multidimensional suffering<sup>2</sup> involves an interdisciplinary team of health carers to respond to a particular person's needs. Palliative care is provided in conjunction with appropriate disease-specific treatment, and hospice staff work in collaboration with the oncologist, GP, HIV clinic and other health care resources.

Is palliative care only for cancer patients? Palliative care developed as a response to cancer patients experiencing severe pain as their disease progressed. The principles and practice of palliative care are effective in the care of patients with any life-threatening illness, and many particular palliative care skills such as empathetic communication skills and control of distressing symptoms are applicable in any health care setting. Patients with heart failure, progressive neurological disorders, renal failure, and advanced HIV also benefit from palliative care. The WHO paediatric definition states that palliative

care 'principles apply to other paediatric chronic disorders'. This is also true of adults with chronic illness, but is a hospice the most appropriate place of referral for patients with chronic illness?

One of the benefits of palliative care is that it can be provided in any setting – the patient does not have to come to a health care facility to access such care. The palliative care practitioner can bring care to the patient – in the GP's rooms, hospital, emergency unit, ICU, frail care centre, hospice, and patient's home. The only requirement is that the health care practitioner – doctor, nurse, oncologist, HIV clinician – is trained in palliative care and applies the appropriate principles to the stage of the person's illness.

Palliative care personnel have identified that, in order to provide appropriate care to patients with progressive illness, it is important to discuss a person's wishes while she/he is still able to have such conversations. It is also important to develop an appropriate care plan – but how can one identify these patients, given the recognised uncertainties of prognostication?

The Gold Standards Framework<sup>3</sup> in the UK, which advises on establishing a palliative care service in general practices, recommends three triggers for palliative care:

- the surprise question<sup>4</sup> – would you be surprised if the patient were to die within the next 6 - 12 months?
- patient choice or need
- clinical indicators – specific indicators of advanced disease for three groups of patients: cancer, organ failure, elderly frail/dementia. In South Africa we would also include patients with advanced HIV and those with XDR TB, with particular challenges for comprehensive care.

The answer to the question posed in the title of this article is that palliative care can be offered from the time of diagnosis of a life-threatening illness; it can be provided by any health care practitioner trained in the discipline; and it can be provided in any setting, including the patient's home.

### Summary

Palliative care may be provided from the time of diagnosis of a life-threatening illness. Palliative care is appropriate for patients with any life-threatening illness.

Patients who could benefit from palliative care may be identified by considering the 'surprise' question – would you be surprised if the patient were to die within the next 6 - 12 months?

All health care practitioners should be trained in palliative care.

References available at [www.cmej.org.za](http://www.cmej.org.za)

## 'Doctor, my pain is getting worse. Please help me.' Some thoughts on opioid-induced neurotoxicity

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It is usually possible to deal with severe pain in patients with advanced cancer by following basic palliative care principles. Occasionally, however, a patient whose pain had previously been well controlled suddenly starts experiencing pain again.

'Doctor, my pain is getting worse. Please help me.' This is a real challenge for any doctor. Consider the following possible reasons for this change:<sup>1-7</sup>

- The disease has progressed. The appropriate response would be to increase the dose of the analgesics.
- Coping with cancer is challenging. At times the patient's ability to manage is overwhelmed and this distress is expressed in excessive somatic complaints that have no organic basis. Somatisation needs careful exploration rather than more analgesia.<sup>7</sup>
- The patient has developed pharmacological tolerance to the dose of their current analgesics and the dose should be adjusted.<sup>1-3,7</sup>

- The previous reduction in pain has allowed the patient to be more active and the current dose is too low for such additional physical activity. This patient needs a more flexible regimen to allow for incidental activity.<sup>1,2</sup>

Let us imagine that you have explored the patient's emotional state and you decide the increased pain is not due to somatisation. Careful examination reveals no evidence of further disease progression. So you decide that the patient has developed pharmacological tolerance and you increase the dose of the opioid analgesic by 30% as recommended by the palliative care consultant, Dr Mary Smith, whose lecture you attended last week.

The next day, much to your surprise, things have deteriorated. 'Mr Jones is not well today,' says Sr Margaret, 'he has become very drowsy. The night staff reported that he was restless and complaining of strange animals in his room'. As you examine Mr Jones you notice brief, irregular jerking of the muscles of his right arm. There is also twitching of his facial and abdominal muscles. He grimaces even when you touch him lightly. 'You've got to help me, doc. This pain is unbearable.'

What's going on now? You did what the expert advised and now things are worse. Fortunately you have the consultant's emergency number. You call and explain

the situation. 'It's the paradoxical pain of opioid-induced neurotoxicity (OIN) with hyperalgesia,' Dr Smith replies. She goes on to explain that although morphine does not have the limitation of a maximum dose like many other analgesics, sometimes OIN occurs. In some individuals, particularly in the context of mild dehydration or deteriorating renal function, there is a build-up of morphine metabolites, especially morphine-3-glucuronide. These metabolites bind to the  $\mu$  receptors and block the analgesic effect of morphine. In addition they stimulate the nervous system and cause myoclonic jerking, confusion and hallucinations. Sensitivity to light touch, allodynia, is another feature of OIN.<sup>1-7</sup>

'That's fascinating but what do I do now?' you ask, 'Should I give naloxone to reverse the condition?' Dr Smith calmly responds 'No, that would just make things worse as you would precipitate an acute opioid withdrawal syndrome with severe pain and even convulsions.'<sup>7</sup>

'Here is what you can do,' continues Dr Smith:<sup>1-7</sup>

- 'Reduce the morphine by 50% or change to a fentanyl patch. This will allow the kidneys to gradually clear the morphine metabolites without leaving Mr Jones in agony. Another alternative would be to use sublingual buprenorphine every 8 hours. It's a pity we don't have methadone

available here as that also works well in this situation.<sup>1,4</sup>

- 'Encourage adequate hydration. If he cannot drink enough oral fluids, you could give 1 litre of normal saline by subcutaneous infusion (hypodermoclysis) over 24 hours.<sup>7</sup> This is a simple procedure. Insert a butterfly needle into the subcutaneous tissues on Mr Jones's abdomen and attach the IV solution to it. This is far less troublesome than an IV line and you won't get called out at 2 am to re-site an IV cannula.
- 'If Mr Jones is not already on paracetamol, add 1 gm 6 hourly orally but avoid non-steroidal anti-inflammatory drugs as they may aggravate the condition. If you get desperate, dexamethasone has been recommended in the literature.<sup>2</sup> Personally I have never found that necessary yet as OIN usually settles down over a day or so.'<sup>6</sup>

The next day Mr Jones is all smiles: he is eating and drinking well. He is looking forward to watching the World Cup rugby final on Saturday. You are pleased that everything has turned out well but there is obviously more to learn about good palliative care and you decide to register for the Diploma in Palliative Medicine at the University of Cape Town with Dr Liz Gwyther.

References available at [www.cmej.org.za](http://www.cmej.org.za)

## SINGLE SUTURE

### *Red wine chemical unlocked at last*

Fancy receiving the heart-protecting abilities of red wine without having to drink a glass every day? Soon you may be able to, thanks to the synthesis of chemicals derived from resveratrol, the molecule believed to give wine its protective powers. The chemicals have the potential to fight many diseases, including cancer.

Plants make a huge variety of chemicals, called polyphenols, from resveratrol to protect themselves against invaders, particularly fungi. But they only make tiny amounts of each chemical, making it extremely difficult for scientists to isolate and utilise them. The unstable nature of resveratrol has also hindered attempts at building new compounds from the chemical itself.

Scott Snyder and his team at Columbia University in New York have found a way around this: building polyphenols from compounds that resemble, but are subtly different to, resveratrol. These differences make the process much easier. Using these alternative starting materials, they have made dozens of natural polyphenols, including vaticanol C, which is known to kill cancer cells.

'It's like a recipe book for the whole resveratrol family,' says Snyder. 'We've opened up a whole casket of nature's goodies.'

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