PALLIATIVE CARE TIPS

Issue # 13 **FAQ's #2 (Frequently Asked Questions) of the Terminally Ill or Their Families: Useful Information**

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RELATING TO CANCER PROGRESSION

What will happen to me as my illness gets worse?

The course depends on the nature of the illness. Although accumulated evidence supports an approximate idea about survival, applying this statistical data to each individual in whom there are multiple unique factors is still challenging. One can give an idea of days vs weeks vs months: patients/families must understand that this is **an estimate**. It is also difficult to predict the precise course for each individual: each human being's response to a given illness differs. One can discuss **possible** complications (pathological fractures, DVT, pulmonary embolism, pneumonia, etc), but not predict the certainty/timing of an occurrence. With disease progression, most people become weaker and less and less aware of their surroundings. Causes of death: infection (~50%), cachexia, renal/liver failure. Although death is approaching, mouth/bowel/skin care & medications primarily for symptom relief should be continued when appropriate, in order to respect patients' dignity.

Will I suffer a lot?

People who are going through the dying process may lose clarity of thought as part of the illness process, such that they may not be aware of intensive symptoms as much as when they are clear. In the vast majority of patients, common symptoms such as pain, nausea, some shortness of breath, constipation can be well palliated. However, asthenia (profound tiredness) and anorexia-cachexia syndrome are difficult symptoms to be alleviated. It is often recognized that family members project their own suffering onto their loved ones when patients are no longer able to express their illness experience.

RELATING TO OPIOIDS

What if I become addicted to morphine?

While anyone using regular opioid therapy will experience physical withdrawal symptoms on abrupt discontinuation, psychological addiction (illicit use, drug hoarding, multiple doctoring for prescriptions, etc) is extremely rare when patients use opioids with the intention to relieve their physical suffering, such as pain or shortness of breath, but not for relieving their psychological distress. If a history of abuse exists, opioid use is still appropriate, although monitoring must be more vigilant. Respiratory depression risk is also not an issue, except for methadone (consult pain/palliative specialist), if opioid titration is appropriate.

If I start morphine now, will it still work for me when my pain gets really bad?

Tolerance to opioids may occur, especially with higher doses or prolonged use. However, if pain control deteriorates, one may consider switching to another opioid if appropriate. (The equianalgesic dose of the new opioid should be reduced by ~25% due to cross-tolerance between opioids).

Isn't it true that I will get horribly constipated if I start taking morphine?

Constipation is a very important side effect of all opioids, to which tolerance does not occur. Common approaches such as high fiber diet/fiber products are insufficient to counteract opioid-induced constipation. Combinations of docusate, senna, +/- lactulose, along with bisacodyl suppositories, enemas & adequate hydration are necessary: these should be **started along** with opioid therapy (See Palliative Care Tips #3).

RELATING TO ANOREXIA/CACHEXIA SYNDROME OF ADVANCED CANCER

He's starving to death - can't we feed him through his veins? He'd feel better with some nutrition!

Anorexia causes major psychological stress to patients/families This syndrome is due to host hormone-like substances secreted in response to the tumour (tumour necrosis factor, etc) or secreted by the tumor. These alter normal metabolic processes such that human tissues can no longer utilize nutrients (catabolic state). Considerable experience with total parenteral nutrition in advanced cancer patients has shown neither improved quality of life nor survival benefit with supplemental nutrition, except in situations such as medically stable and high-functioning patients (see Clinical Practice Guideline for home parenteral nutrition - http://www.palliative.org/PC/ClinicalInfo/Clinical%20Practice%20Guidelines/PDF%20files/Home%20Parenteral.pdf). Feeding gastrostomy/jejunostomy tubes may be indicated if locally advanced disease limits swallowing ability. However, they are often found to cause discomfort with respiratory and gastrointestinal symptoms when the patient develops anorexia-cachexia syndrome due to the primary illness. Anorexia causes major psychological stress to patients/families. Family members need to be guided to appreciate that anorexic patients find pressure to eat very stressful. Current appetite stimulants do not increase lean body mass. Megestrol acetate may be contraindicated due to its side effect profile. Future research may provide significantly more effective agents to counteract this troublesome syndrome.

RELATING TO PALLIATIVE RADIATION/CHEMOTHERAPY

Won't radiation/chemotherapy make me very sick? My friend got so sick on it.

Palliative radiation rarely causes nausea: exceptions may be radiation to intra-abdominal masses or lumbar spine (some radiation scatters to intra-abdominal structures). Some palliative chemotherapy agents have few GI side effects (eg: etoposide). Patients should be encouraged to go for oncological consultation re palliative RT/chemo with open minds.

REMEMBER: For referrals, questions, or telephone consultations call 496-1300 weekdays and weekends.
Palliative Care Tips are now available on our Website: www.palliative.org