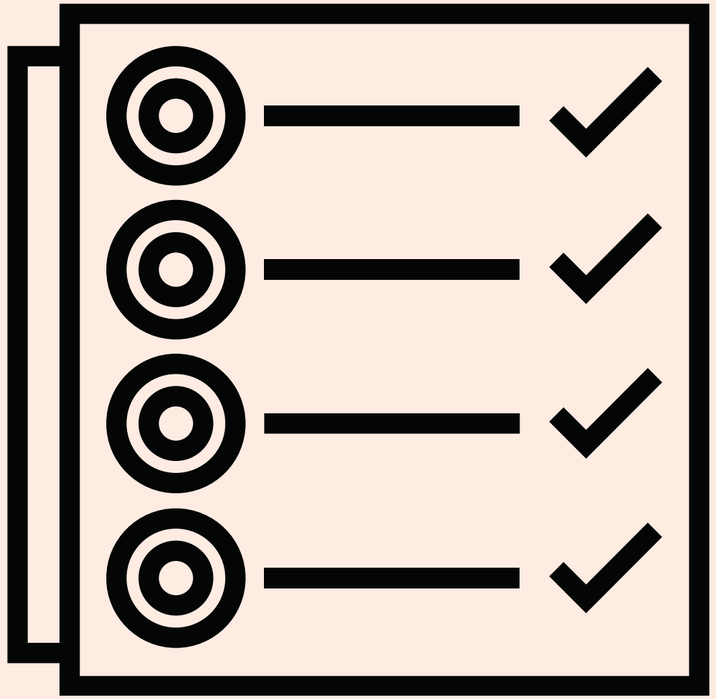
Management of Emergencies & Humanitarian Crises

For MO

OBJECTIVES

- To recognise emergencies in Palliative Care
- Management of emergencies



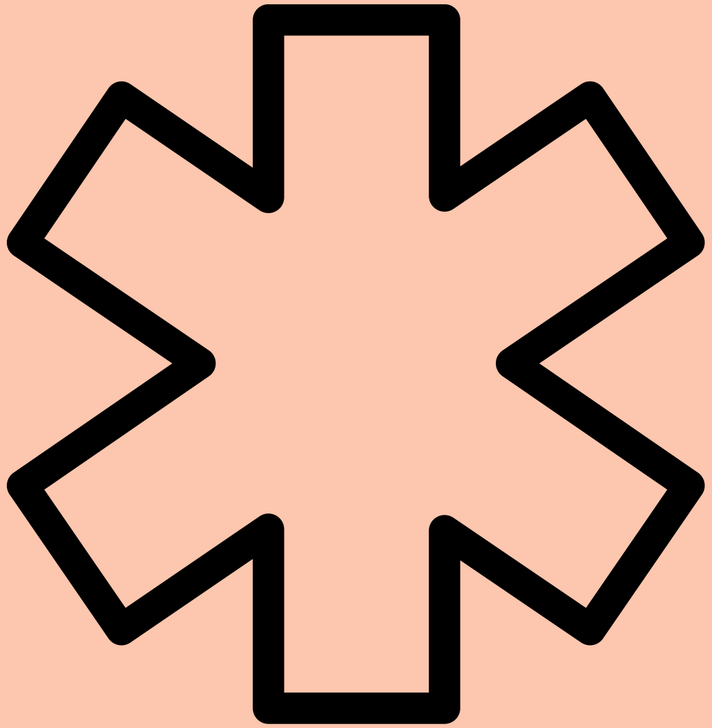
Emergencies: If left untreated, will immediately threaten life

Palliative Care: If untreated, will seriously threaten the quality of life

*Here prolongation of life is not usually a realistic aim

COMMON EMERGENCIES

- Spinal Cord Compression (MSCC)
- Haemorrhage
- Superior Vena Cava Obstruction (SVCO)
- Seizures
- Hypercalcemia
- Stridor, Choking
- Increased intracranial tension
- Acute breathlessness
- Delirium



ASK YOURSELF

Performance Status

Correct the Correctable

Patient and family wishes

Benefit vs Burden

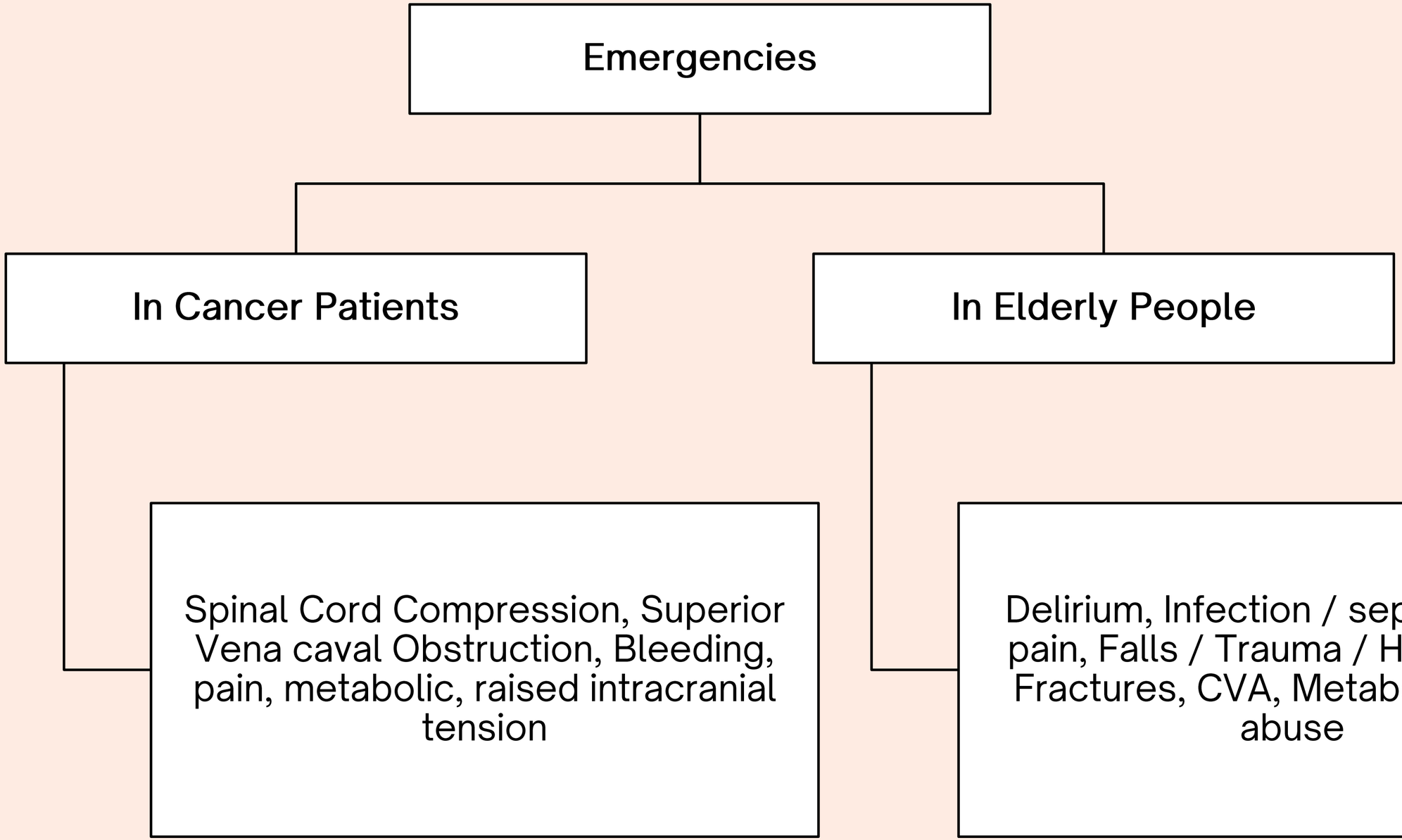
Trajectory and Disease

PERFORMANCE STATUS

Palliative Performance Scale (PPSv2) version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

EMERGENCIES



SCENARIO 1

- Mr Abhishek, 53 years old male was diagnosed to have Carcinoma lung

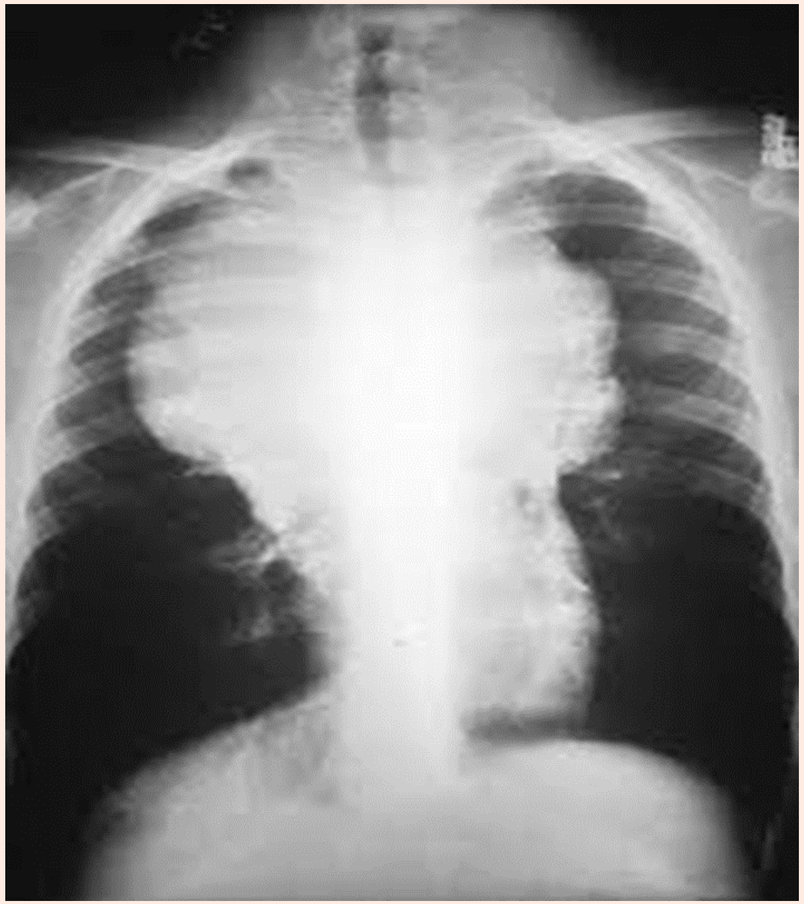
  6 months ago, he was treated with chemotherapy with poor response.

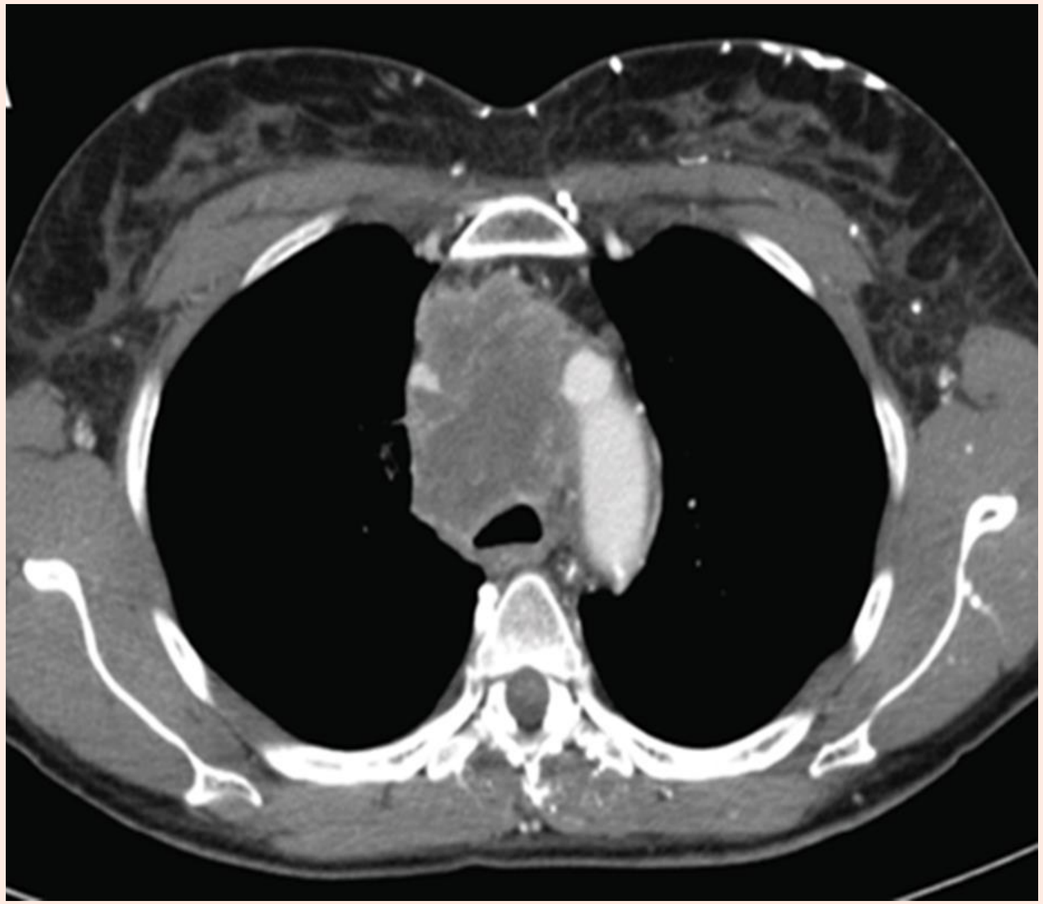
  He has come to OPD with following complaints

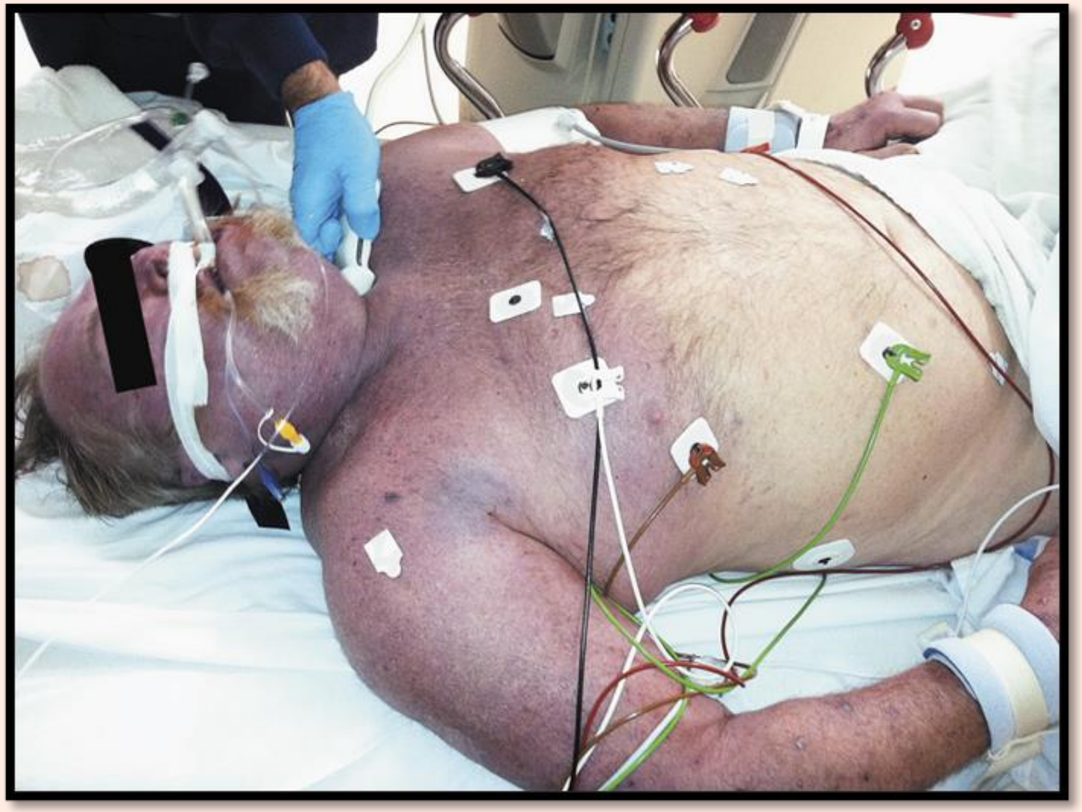
  - Bilateral upper limb edema
  - Breathlessness
  - Prominent chest veins

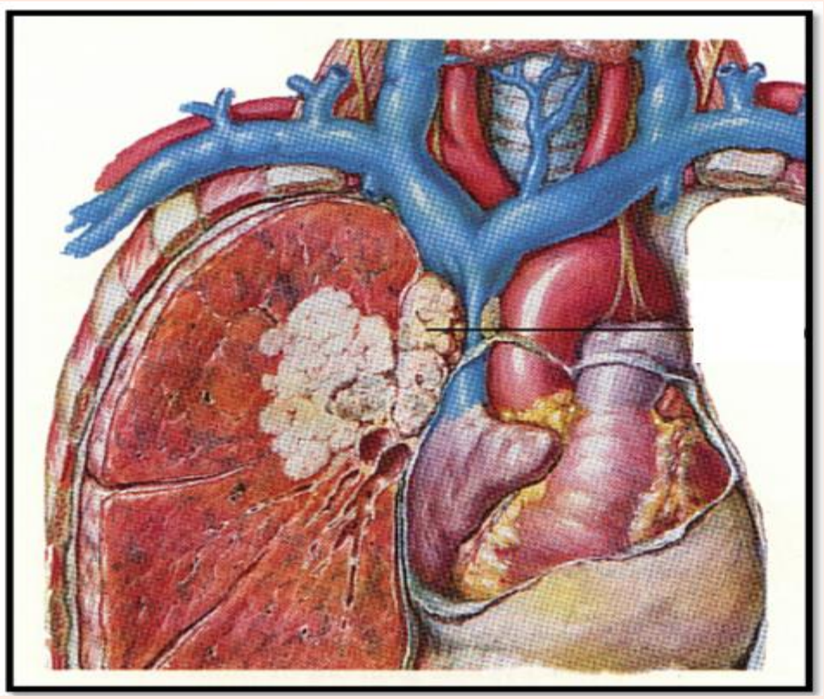
- His breathlessness is not relieved by oxygen and he is restless

RADIOLOGICAL IMAGING

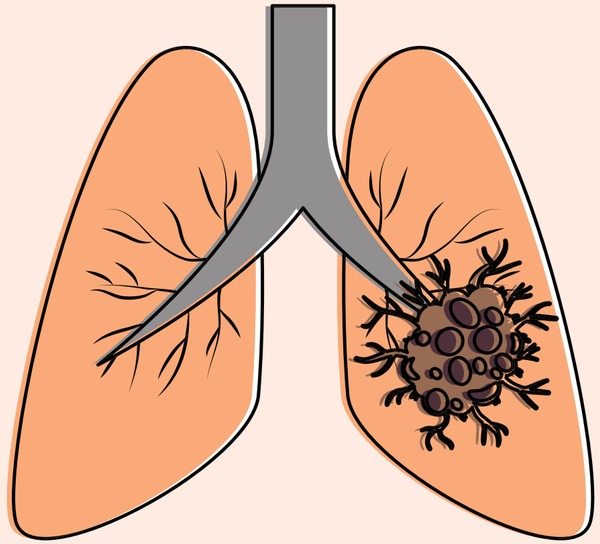








SUPERIOR VENA CAVA OBSTRUCTION SYNDROME



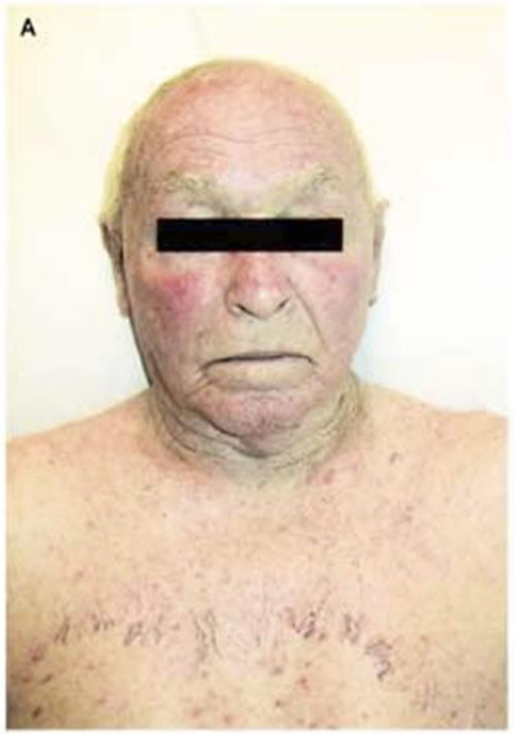
- Seen in
  - Lung cancers
  - Lymphomas
  - Iatrogenic
- Generally occurs over weeks to months giving time for collateral
- Rapid progression becomes an emergency

CLINICAL FEATURES

- Persistent headache and feeling of fullness of the head
- Swelling of the face, upper limb, neck and chest
- JV distention and prominent chest veins
- Dusky coloured skin in the chest and face
- Breathlessness (Severe when lying flat)
- Stridor in severe cases

MANAGEMENT

- Corticosteroids (to relieve peritumour edema)
  - Dexamethasone 12 to 16mg single dose/day
  - PPIs to prevent gastritis caused by steroids
  - Diuretics may be helpful
- For breathlessness
  - Bronchodilators
  - Opioids with or without benzodiazepines
- Referral for further management (Stenting, Chemo-radiation)
- Discuss prognosis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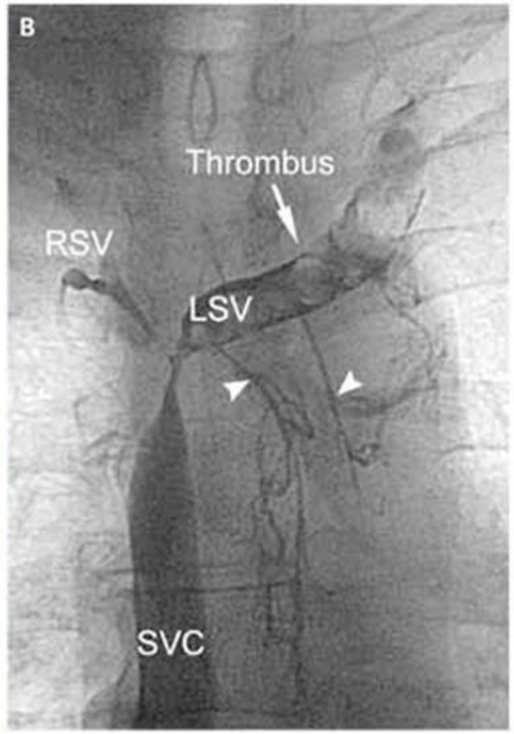
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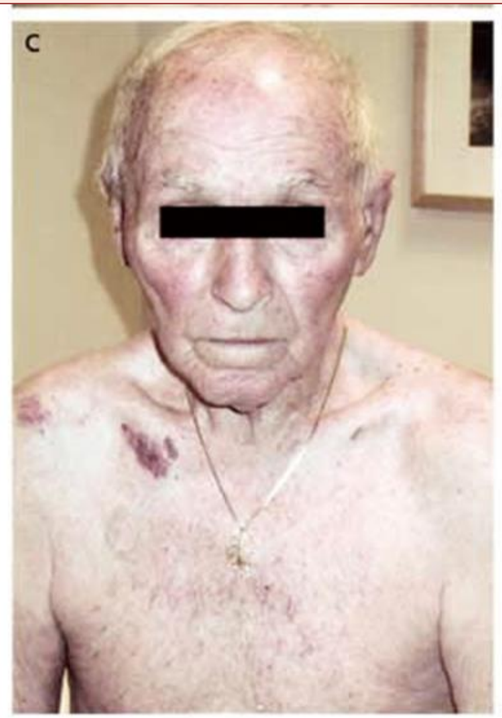
Thrombus
RSV
LSV
SVC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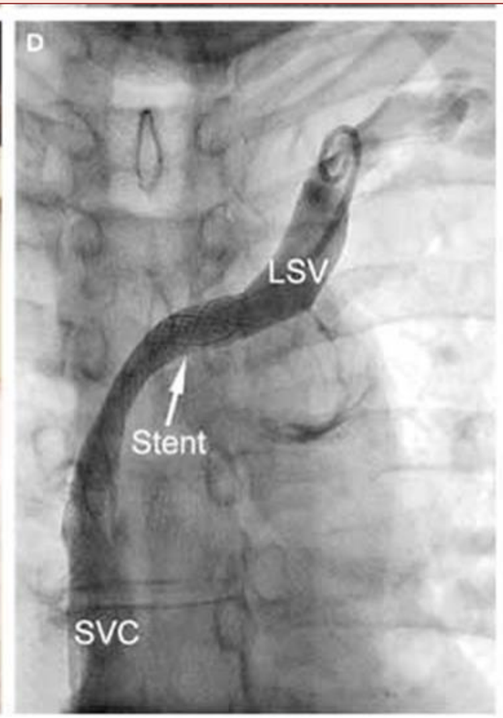

D
LSV
Stent
SVC

HOME MANAGEMENT

- Steroids as per the response
- Continue opioids for pain and breathlessness
- Consider benzodiazepines for anxiety and breathlessness.
- Head-end elevation
- No upper body injections
- Continue other supportive drugs and measures

SCENARIO 2

Mr. Rajesh, a 63-year-old male was diagnosed to have Carcinoma Prostate one year back. On a home care visits he complains of low back pain, weakness of both legs, and urinary hesitancy.

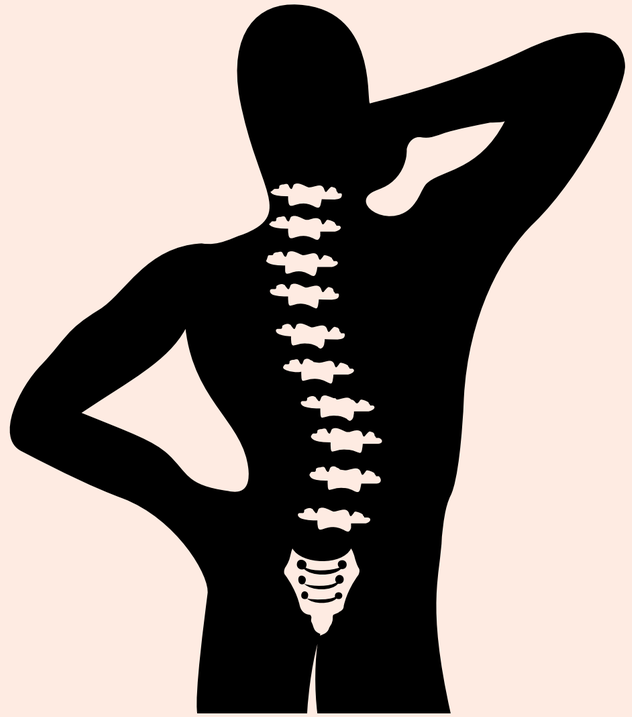
What could be the cause?

IMPENDING SPINAL CORD COMPRESSION

- Early diagnosis and prompt management is crucial in preventing long-term disability

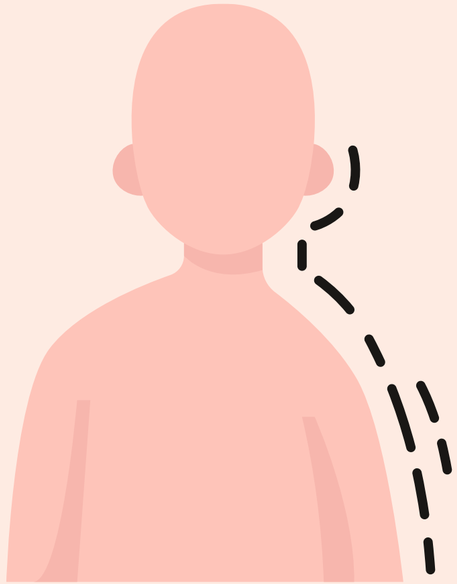
- Common in
  - Carcinoma breast
  - Carcinoma lung
  - Carcinoma Prostate

- Thoracic spine being the most common site



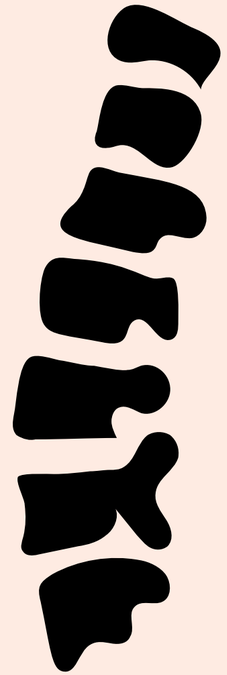
CLINICAL FEATURES

- Pain
  - Severe unremitting pain
  - Aggravated by coughing or sneezing
  - Localized tenderness
  - Pain often worse in recumbent position and at night
- Weakness (patients may complain of fatigue)
- Progressive numbness to sensory loss
- Loss of bowel and bladder sensation
- Paralysis



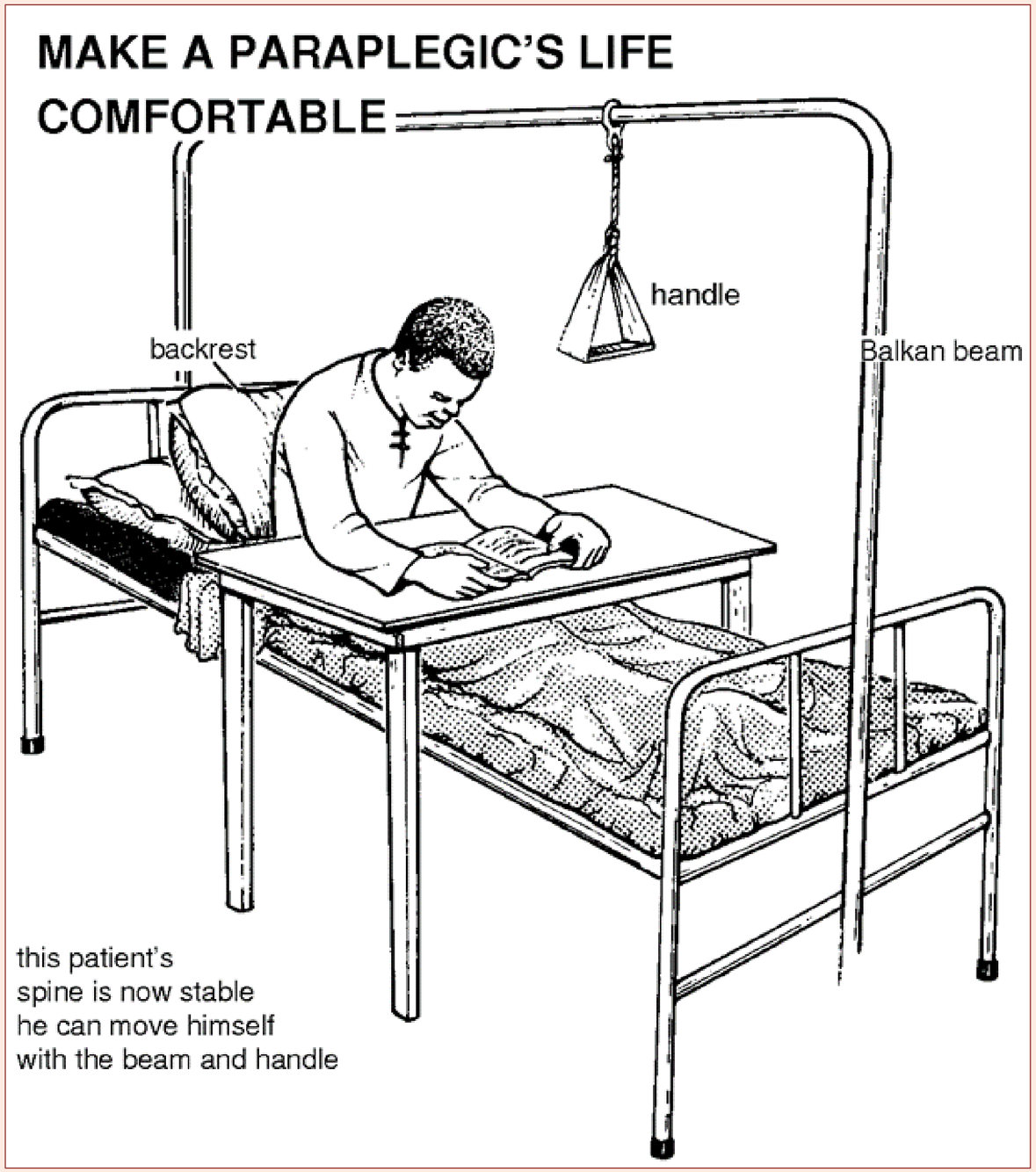
ADMINISTER STEROIDS ON SUSPICION OF SPINAL CORD COMPRESSION

- Inj. Dexamethasone 16mg IV
- MRI is the investigation of choice (but do not wait for MRI to administer steroids)
- Catheterization if urinary symptoms present
- Laxatives if required
- Minimal movement
- Referral further management
  - Radiotherapy (Also helpful in managing pain)
  - Spinal stabilization surgery

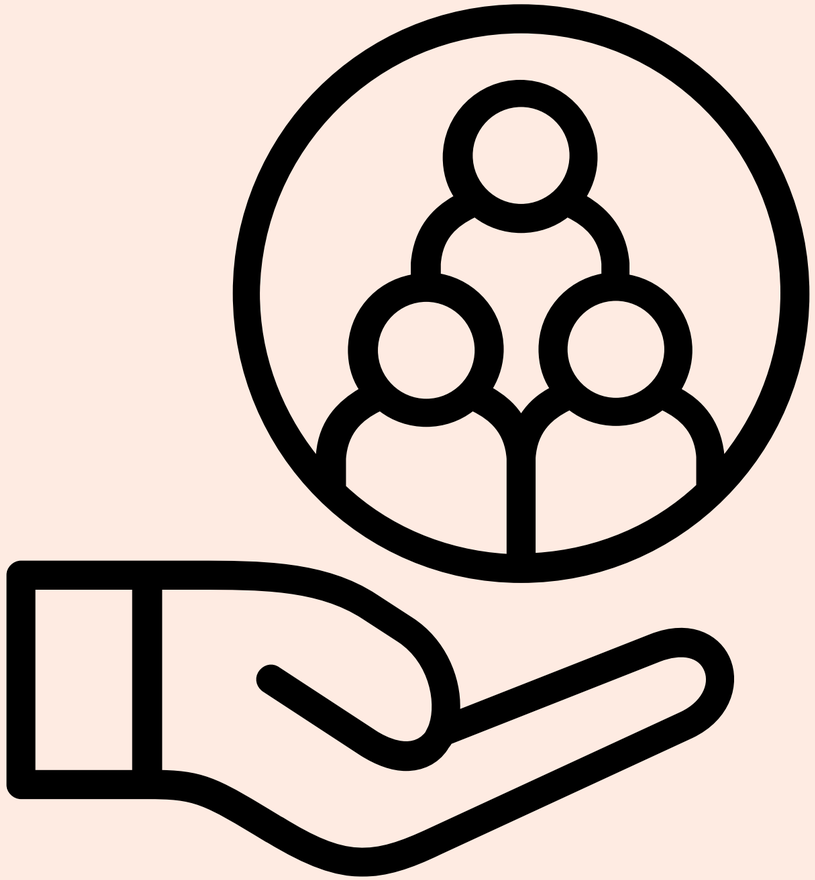


SUPPORTIVE MANAGEMENT

- Passive movements to maintain joint range of motion
- Skin care and prevention of bed sores in a patient confined to bed
- Bowel and bladder interventions
- Mouth Care



- Post RT skin
- Maintaining circulatory and respiratory functioning



Psychosocial support

Access to specialist rehabilitation and transition to care at home

Occupational and physiotherapy assessments- MDT

Teaching cares how to correctly handling activities to maximize patient function and safety

CASE SCENARIO 3

A 16 year old boy has a large fungating ulcer in the neck due to soft tissue sarcoma. The ulcer is painful and bleeds. His pain was under control with step 2 analgesia. Every time the ulcer bleeds while doing dressing. He gets very anxious when he see the bleeding.

How can we manage ?

BLEEDING

- Bleeding is more pronounced in malignant ulcers. For this reason, mechanical and sharp debridement is avoided
- Avoid removing the dry dressing. Always wet the dressing before removal
- Meticulous care should be taken while dressing wounds with a tendency to bleed
- Non-adherent dressing like Vaseline gauze
- Pressure bandaging

- Minor bleeding can be controlled using sucralfate powder dressing or calcium alginate dressing

- In case of profuse bleeding, compressing the wound for 10 minutes with gauze soaked in adrenaline (1:100,000) helps in controlling the bleeding. CAUTION

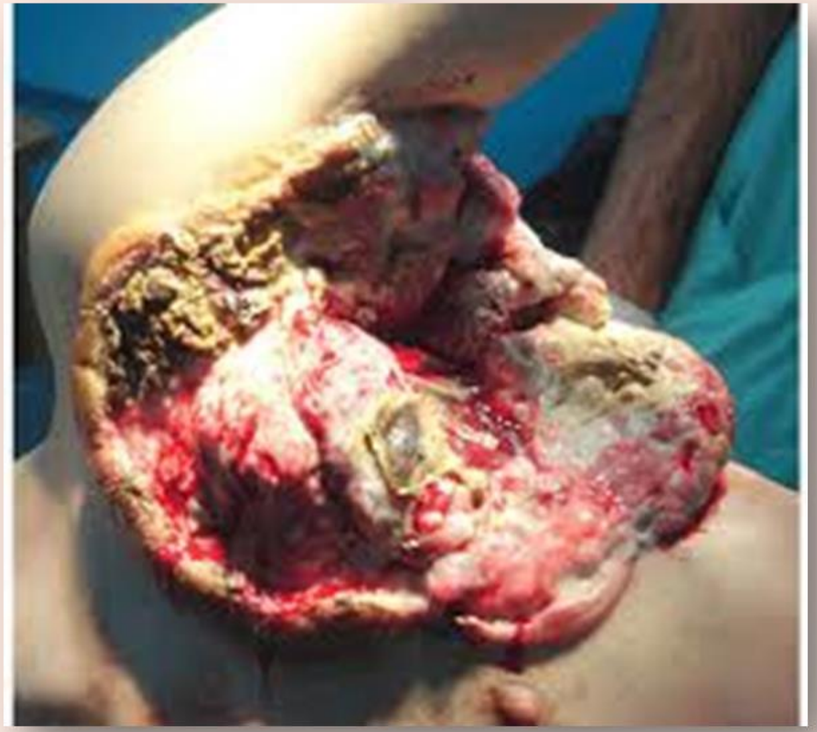
- For nasopharyngeal bleeding, Tranexamic mouth wash can be done twice daily.

- A systemic anti-haemorrhagic agent like Etamsylate and fibrinolytic antagonist like tranexamic acid can help prevent bleeding

- Sentinel bleeding – A harbinger

BLEEDING FROM WOUND

- Malignant fungating wounds do not heal



MANAGING BLEEDING FUNGATING ULCERS

- Tranexamic acid, Ehtamsylate

Wound care:

- Calcium alginate dressing
- Completely wet the dressing before removal
- Sucralfate powder
- Managing his anxiety

WHAT LIFE THREATENING COMPLICATION DO YOU ANTICIPATE ?

CAROTID BLOW OUT

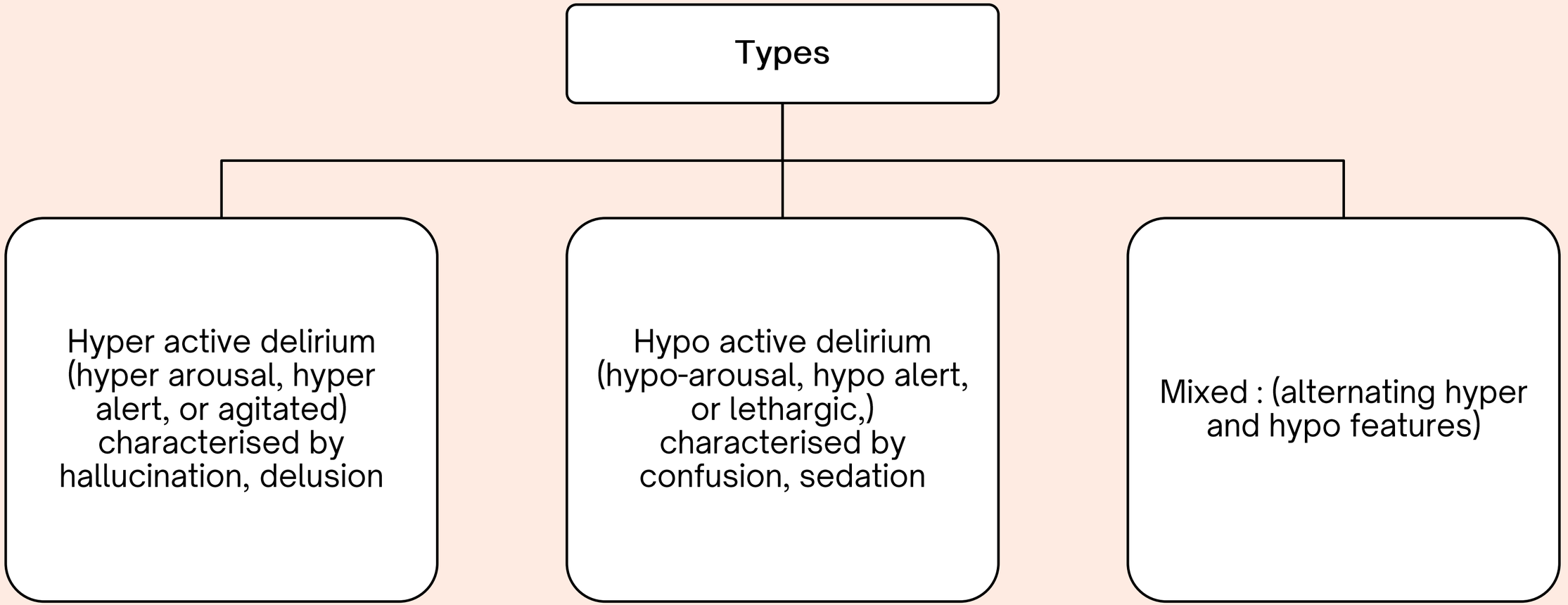
- 1.5 Lt in 30 seconds
- Femoral blow out

SCENARIO 4

- Elderly person
- Changed behavior - three days
- Occasional Hallucinations Normal in between
- History of recurrent mild fever present

What is the condition?

DELIRIUM



Two third are hypo active or mixed type

MANAGEMENT

General Measures

- Adequate hydration
- Control fever if present
- Look for possible causes of physical distress
- Inadequate symptom control
- Developing bedsores
- Bowel
- Urine retention/incontinence
- Preventing delirium

Medical Measures

- Haloperidol – most commonly used
- Use very small doses
- Not more than 3 mg in 24 Hours
- Frail older people need only 0.25 to 0.5 mg
- A small dose at bed time
- Benzodiazepines – Best avoided
- Risperidone /Olanzapine /Quitiapine

NON-PHARMACOLOGICAL INTERVENTIONS






- Repeated reassurance (reduces anxiety)
- Repeated reorientation (reduces disorientation)
- Explaining to the caregivers
- Relieves their anxiety
- Join in reassuring and reorienting the patient

- Simple, Predictable & Consistent Routine
- Appropriate lighting
- Optimal stimulation
- Ensure sleep at night
- Minimum number of caregivers
- Less disturbing surroundings (separate room if needed)

REMEMBER

- Information, education and communication with the patient and family is extremely important
- Emergencies can happen throughout the illness
- Emphasis is on symptom management rather than reversing the disease process
- Quality of life of the UNIT

HUMANITARIAN CRISIS

- Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises: a WHO guide. WHO 2018

- A Field Manual for Palliative Care in Humanitarian Crises. Ed, Elisha Waldman and Marcia Glass. Oxford Medicine Online

HUMANITARIANISM

- Benevolent response to the suffering and needs of others

- It is action to prevent and alleviate human suffering wherever it may be found, to protect life and health, and to ensure respect for the human being

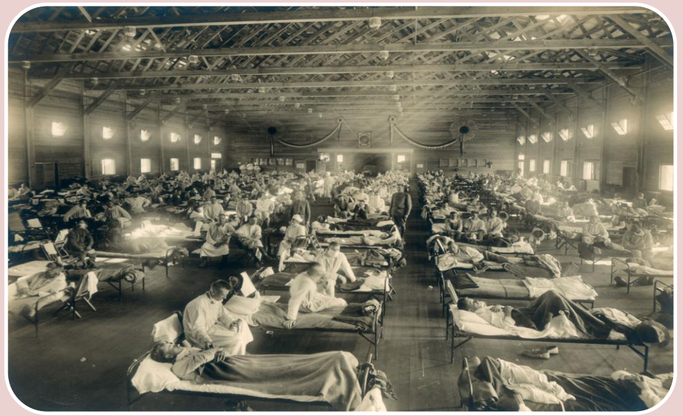
HUMANITARIAN EMERGENCIES AND CRISES

Large-scale events that may result in the breakdown of health care systems and society, forced displacement, death, and physical, psychological, social and spiritual suffering on a massive scale.

- Acute injury and illness
- Chronic and multigenerational physical, mental health and psychosocial consequences

HUMANITARIAN CRISES

Natural hazards (earthquakes, storms, tsunamis, floods)



Epidemics

Wars, political conflicts, ethnic violence

‘INVISIBLE PEOPLE’

During humanitarian crises elderly people and those having chronic and incurable illnesses may become ‘invisible’:

- Difficult access to care facilities due to physical issues
- Multiple diseases / physical problems
- Difficult access to basic needs (competing with others)
- Lower priority during triage
- Shortage of medical supplies
- Inadequately prepared health systems

PALLIATIVE CARE IN HUMANITARIAN CRISES

- Most fundamental goal not only of palliative care, but also of medicine itself, is to relieve human suffering
- Humanitarian responses to emergencies and crises should include palliative care and symptom control
- Any clinician, including those trained in palliative care, should make every effort to save the life of any patient who may be save-able
- Palliative care and life-saving treatment should not be regarded as distinct, but integrated

RECOMMENDED TRIAGE CATEGORIES IN HUMANITARIAN EMERGENCIES AND CRISES

Category	Colour code	Description
1a. Immediate	Red	Survival possible with immediate treatment. Palliative care should be integrated with life-sustaining treatment as much as possible.
2a. Expectant	Blue	Survival not possible given the care that is available Palliative care is require
	Yellow	Not in immediate danger of death, but treatment needed soon. Palliative care and/or symptom relief may nevertheless be needed immediately.
3. Minimal	Green	Will need medical care at some point, after patients with more critical conditions have been treated. Symptom relief may be needed.

Source: Adapted from Hayward-Karlsson et al. 2005 *(33)*, and WHO/ICRC 2017.

Group Activity

Covid 19 Pandemic, a humanitarian crisis

- **Group A:** Physical Suffering
- **Group B:** Psychological /Emotional Suffering
- **Group C:** Social Suffering
- **Group D:** Spiritual Suffering

Discuss type of suffering and what remedy will you provide

PHYSICAL SUFFERING

Symptoms due to acute injury or illness

- Put in place policies clarifying that humanitarian medical assistance aims both to save lives and to relieve suffering
- Develop protocols for symptom assessment and treatment
- Train and equip health care providers with minimum standards of care
- Include the essential package of palliative care medicines and equipment for Humanitarian emergencies and crises in all emergency health kits

PSYCHOLOGICAL SUFFERING

Can cause: Acute anxiety, acute depressed mood, acute grief/PTSD, chronic anxiety disorders, chronic depression, complicated grief, survivor's guilt.

- Train health care providers with protocols for psychological symptom assessment and treatment
- Offer training to local volunteers to provide basic mental health interventions
- Organize support groups for patients and survivors who may wish to share experiences and challenges

SOCIAL SUFFERING

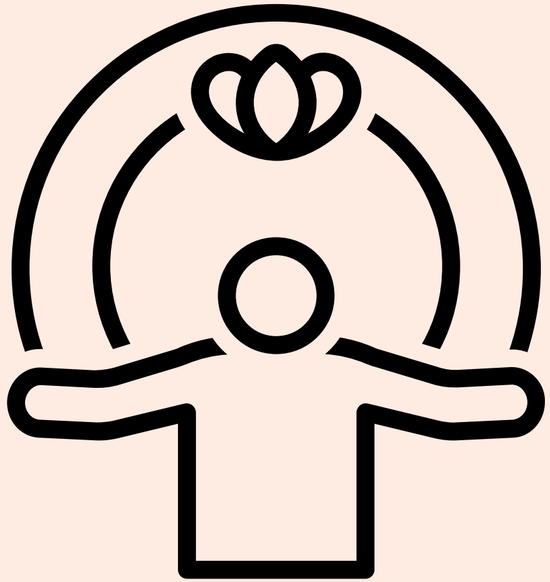
Social stigma (patients, family members, survivors)/Social isolation

- Conduct community education about the infectious disease to reduce fear and stigma
- Organize voluntary psychosocial support groups for patients, survivors and bereaved family members

SPIRITUAL SUFFERING

Loss of faith/anger towards God /Loss of sense of meaning of life

- Seek partnerships with local spiritual counsellors willing to visit patients and family members



Thank You