

The Palliative Care Handbook

Guidelines for clinical management
and symptom control, featuring extensive
support for advanced dementia



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Skin

Itch (pruritus)

Itching can be as unpleasant and disruptive as pain and can have just as adverse an effect on quality of life.

- nerve fibres involved in the itch process are anatomically very similar to those involved in pain with opioid receptors being involved in both pathways
- cholestatic and uraemic itch in particular are mediated via opioid receptors
- the skin can be affected by many metabolic, pharmacological, dietary, environmental and psychological factors
- an accurate history of the onset and nature of itching is essential and will help to identify a cause along with examination of the skin for signs of disease
- not all itch is histamine related
- serotonin and prostaglandins may also be involved
- both central (neuropathic) and peripheral (cutaneous) itch have been identified

Causes

- hepatic/renal disease (obstructive jaundice, cholestatic and uraemic itch)
- drug allergy
- drugs e.g. opioids, vasodilators
- endocrine disease
- iron deficiency
- lymphoma
- provocative sensory influences such as rough clothing
- parasites

Management

- treat/remove causes
- attempt to break the itch/scratch cycle by short clipping nails, wearing cotton gloves, applying paste bandages
- apply surface cooling agents with emollients e.g. 0.25 to 1% menthol in aqueous cream, tepid showers, humid environment
- avoid washing with soap and use emulsifying ointment instead and Alpha-keri™ as bath oil
- light therapy may help
- drugs
 - oral anti-histamines e.g. promethazine, cetirizine
 - bile sequestrant e.g. cholestyramine 4 to 8 g per day
 - night sedation e.g. temazepam
 - H2 antagonists (act on histamine receptors in the skin) e.g. cimetidine 400 mg twice daily
 - NSAIDs e.g. diclofenac
 - anxiolytics e.g. benzodiazepines

- chlorpromazine 10 to 50mg TDS
- steroids e.g. dexamethasone (lymphoma itch), topical hydrocortisone
- rifampicin 150 to 300 mg per day (chronic cholestasis)
- 5HT3 antagonists e.g. ondansetron (uraemic)
- gabapentin (uraemic)
- doxepin capsules or cream
- thalidomide
- paroxetine, mirtazapine (paraneoplastic itch)

Referral to a specialist dermatologist should be considered at an early stage if no alleviation of symptoms is obtained.

Sweating

Sweating is an unpleasant and debilitating symptom that affects not only the patient but often indirectly, the carers as well. As with many other symptoms it can indicate physical, psychological and/or environmental disturbance.

Causes

- environmental temperature changes
- emotion
 - usually confined to the axillae, palms and soles
- lymphomas, hepatic metastases and carcinoid
 - may produce drenching night sweats
- intense pain precipitating or manifesting through anxiety and fear
- infection
- drugs
 - alcohol
 - antidepressants (especially venlafaxine)
 - opioids

Management

- treat/remove causes
- drugs
 - NSAIDs e.g. diclofenac
 - > act via prostaglandins in the hypothalamus
 - cimetidine 400mg to 800 mg at night
 - > acts on histamine receptors in skin
 - steroids e.g. dexamethasone
 - paracetamol (for night sweats)
 - gabapentin
 - glycopyrrolate topically

Pressure injury care.....

Pressure injuries occur when the blood supply is shut down by pressure e.g. from a hard bed or other surface resulting in tissue death.

Causes

- pressure on one particular part of the body
 - sitting is riskier than lying as more of a person's weight can press on a smaller area e.g. buttocks while sitting
- sliding patients against a surface can cause damage to skin (friction) or tissue (shear)
- wetness increases the risk of pressure injury damage

Assessment

- A comprehensive assessment should include:
 - clinical history
 - pressure injury risk scale
 - skin assessment
 - mobility and activity assessment
 - nutritional assessment
 - continence assessment
 - cognitive assessment
 - assessment of extrinsic risk factors

Management

- avoid causes
- assess using appropriate 'risk factor scale' at regular intervals i.e. daily for high risk, weekly for low risk
- use pressure relieving aids and mattresses when these are available and assessed as being needed
- use aids to movement where appropriate
- discuss management with patient and home carers
- use a semipermeable adhesive dressing if at risk
- where semipermeable adhesive dressing is not practical use meticulous hygiene followed by povidone iodine spray
- higher rating pressure injuries should be treated as wounds with appropriate dressing products and techniques
- rubbing over pressure injuries should be discouraged
- turn bed-fast patients every 2 to 4 hours as appropriate
- in incontinent patients protect vulnerable skin with zinc and castor oil cream and consider catheterisation
- if nutritional state is poor, get dietary advice from a dietitian
- inform primary carers of management on discharge from in-patient facility

Lymphoedema

As lymphoedema (swelling of a limb [usually] due to fluid) cannot be cured, the aim of treatment is to achieve maximal improvement and long-term control.

Causes

- damage to the lymphatic drainage system allows fluid to build up
- the protein in the initial oedema draws more fluid out of the blood
- the protein in the fluid also encourages inflammation
- infection may occur

Management

- provide analgesia if painful
- early referral to an appropriately trained professional (usually a physiotherapist) produces best results
- success requires the patient's full cooperation, so management may be suboptimal in those with significant cognitive impairment. In others, a simple explanation of lymph flow and the cause of swelling is essential, together with instruction on daily skin care
- infections must be cleared before commencing treatment
- gentle massage of the affected area helps to shift fluid from one area to another, local practitioners in the techniques may be available
- regular measurement of both normal and affected limbs is essential to monitor progress
- in most cases containment hosiery of an appropriate size and strength should be worn all day, complemented by specific exercises and massage if possible
- if the limb is not in a suitable shape or condition to use hosiery or if the fingers are swollen, compression bandaging or taping may be necessary for approximately 2 weeks
- diuretics are not usually useful (except when the patient has heart failure or hypoalbuminaemia), may be detrimental and can cause dehydration

Fungating wounds and tumours

Fungation of wounds or tumours (smelly, exuding necrotising wounds) presents an obvious manifestation of disease that can cause major distress to patient, carers and family.

- 'fungating' wounds are malignant in nature and combine ulceration with proliferation
- usually seen in the area of the breast or head and neck
- as healing of the wound is rare, the aim in managing these wounds is to achieve maximum patient comfort together with a reduction in the distortion of body image
- odour is often caused by anaerobic bacterial infection of compromised tissue
- the wound may bleed as blood vessels are eroded

Causes

- primary skin tumour e.g. melanoma, squamous cell carcinoma

- invasion of nearby tissue by underlying tumour e.g. breast cancer
- metastatic involvement

Management

- ensuring that the area is as clean as possible can help to reduce smell and exudate
- many preparations are recommended for odour reduction and each practitioner will have their favourite e.g. lemon oil
- as the odour is often due to anaerobic infection, metronidazole gel applied directly to the wound can be helpful
- for excessive exudate wound dressings may be used on the advice of a local expert - disposable nappies may be an option
- bismuth idoform paraffin paste (BIPP) may help in drying up the wound and reducing odour
- many fungating wounds are painful - use systemic analgesics
- morphine injection added to a gel in a clean environment and used topically may help (0.05 to 0.1% morphine [i.e. 0.5 to 1 mg/mL] in Intrasite™ gel, metronidazole gel or KY Jelly™)
- radiotherapy, chemotherapy and hormone manipulation should be considered for some tumours
- if bleeding consider pressure with adrenaline 1:1000 soaked swabs