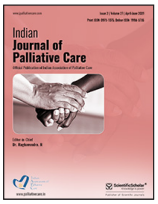
ScientificScholar®
Knowledge is power
Publisher of Scientific Journals

https://jpalliativecare.com/

Indian Journal of Palliative Care



Poster Presentation: Awardees

DAY-1

PP-101_68

Management of Malignant Bowel Obstruction(MBO) in the Community: A Single Centre Experience

Daniel Raj J, Meenakshi V Venketeswaran, Thendral Ramasamy

Cancer Institute(WIA), Adyar Chennai-600036.
Email: dr.j.danny@gmail.com; Mobile: 9566997109

Introduction: Malignant Bowel Obstruction(MBO) heralds a poor prognosis especially when it is inoperable. Multimodality treatment is used to relieve the symptoms in these patients often requiring hospital or hospice admission. The management includes addressing the symptoms, maintaining nutrition and hydration. With proper communication and empowering the caregivers these patients can be effectively managed at home.

Aim: To describe our clinical experience in managing patients with MBO in the community setting.

Methods: Records of patients who died with inoperable MBO from November 2021 to October 2022 were evaluated retrospectively. Data on the presenting symptoms, treatment received and days of survival after diagnosis were obtained.

Results: Fourteen patients diagnosed with MBO were managed by the palliative care team. The patients outside the city limits were given periodic telephonic support and patients within the city were managed by the home care team. Most common symptoms managed included pain and vomiting. Naso-gastric tube was retained only for 2 patients. Few received parenteral hydration. One patient was sedated at home as per patient's preference. Median days of survival after diagnosis of MBO was 24.5 (5-168) days. Patients spent a median of 12.5 (2 - 166) days at home.

Conclusion: Given good palliative care support, patients with malignant bowel obstruction can be managed effectively at the place of their choice.

PP-212_239

IAPCON 23

Intensive Care Palliative Care -Communication -Oral Presentation

Communication is Key in End-of-Life Decisions -View Point

Dr Radha M G Idccm, Fnb, Ccidc

Senior Consultant Intensivist, Ramaiah Memorial Hospital Bengaluru.
E-mail: radha_moda@yahoo.co.in; Mobile: 9902306261

Introduction: Dignity and quality of life are equally important. Death must be respected always. In Our culture, death is respected equally.

ॐ असतो मा सद् गमय।
तमसो मा ज्योतिर्गमय।
मृत्योर्माऽमृतम् गमय ॥

Om, Asato Maa Sad Gamaya;
Tamaso Maa Gyotira Gamaya;
Mrityora Maa Amritam Gamaya

Lead me from the unreal to the real;
from darkness (ignorance) to light (knowledge);
and from death to immortality.

"Death is not extinguishing the light; it is putting out the lamp because the dawn has come." - Rabindranath Tagore.

Recognizing medical futility and the dying process is the first step in providing end-of-life care (EOLC). A reasonable prediction of mortality is essential to identify the patients in whom EOLC discussions can begin. These should be based on the physician's objective and subjective assessment of medical futility and the dying process.

MY observations with respect to End of life in ICU are accepted well with comprehensive communication and interdisciplinary meetings with family and surrogates.

Key factor is knowledge provided to the patient and family in the beginning of diagnosis of certain diseases with downhill trajectory. Examples are malignant CVA, Severe LV dysfunction .Progressive kidney injury, Malignant metastatic cancers, so also in chronic diseases like DM, HTN, CAD. More important is the discussion by the family doctor.

Everyone with a life limiting illness has a right to a life free from pain and distress, psychosocial or spiritual, and also the right to a dignified life that includes the process of death.

Though natural course of many diseases to some extents are predictable, many other factors contribute to better understanding the same.

Education, religion, spirituality, beliefs play role. In fact people from Villages, Orthodox families comply better with adequate discussions.

Communication should be taught in undergraduate curriculum and distinction of Curative and palliative medicine in which End of life care is vital, also needs to be included. Fragmentation of these distinctions by different clinicians causes confusion amongst doctors and families.

Prompt identification of irreversible disease processes are essential to prevent any malfiasance. Patients, families, and health care providers should be educated about appropriateness of ICU admission, nature of ICU interventions including resuscitation, outcomes and futility of these interventions, and detailed information on alternatives to ICU admission. Good palliative and EOLC are not just the alternative, but also a superior and most appropriate mode of treatment when compared to inappropriate ICU admission.

PP-227_253

Utilisation of Non-Pharmacological Interventions for management of Cancer Related Fatigue in Palliative care Services - An Audit

Vidya Viswanath[1], Priyanshu[1], Dolorosa Fernandes[2], AlishaKarim[1], Dharun Prasad[2], Neeharika Alapati[3], Gayatri Karnik[4], Raviteja Miriyala[5]

[1]Department of Palliative Medicine; [2]Department of Preventive Oncology; [3]Department of Medical Oncology; [4]Department of Onco- Physiotherapy; [5]Department of Radiation Oncology
Homi Bhabha Cancer Hospital and Research Centre, Visakhapatnam.

Introduction: Cancer Related Fatigue (CRF) is one of the most prevalent and complex symptoms in patients with cancer.[1] Management principles are based on the severity of fatigue and illness trajectory. As the contributors to fatigue are varied, a multidisciplinary team (MDT) approach is recommended with non-pharmacological interventions (NPIs) being the first line of management.[2]

Aim: The purpose of this audit was to study the documentation of fatigue and NPIs planned. The set standard was 100% for both. The secondary objective was to analyse symptom clusters associated with fatigue.

Methods: MDT was inducted in the Department of Palliative Medicine in 2022. To assess the impact of MDT on documentation of CRF and NPIs, case records of adult patients with cancer, in March 2021 and March 2022 were retrospectively audited. Statistical analysis was done using Epi Info.

Results: In 2021 (n=391), 67% had documentation of fatigue with 0% documentation of NPIs in the case records**.** In 2022 (n=433) there was a substantial improvement in the documentation of fatigue (84%) and NPI (36%). Symptom clusters associated with fatigue varied between 2021(depression, drowsiness, breathlessness, loss of wellbeing) and 2022(loss of appetite, loss of wellbeing, nausea and pain) likely due to improved documentation.

Conclusion: Induction of MDT resulted in improved documentation of CRF and NPIs; however, the set standard of 100% could not be achieved. Additional interventions to further improve documentation (monthly run chart and codes to document NPIs) have been introduced based on this audit.

REFERENCES

1. S Januja *et al*., Physical activity for the management of cancer related fatigue in adults. Cochrane database of Systematic reviews. 2022(12)
2. Ghoshal A *et al*., EBM guidelines- Current Concepts and Controversies in Palliative Medicine Part C ISBN: 978-93-82963-54-7, 2020

DAY-2

PP-94_62

Outcome of Advanced Cancer Patients Referred for Specialist Palliative Care in Emergency Department

Isha Jatin Shah, Jayita Deodhar, Raghu Thota, Ajila Ajith, Varun TM, Shruti Kamble

Tata Memorial Hospital, Mumbai.
Email: sisha4574@email.com; Mobile: 7021684675

Introduction: Advanced cancer patients (ACP) are referred from Emergency Department (ED) for symptom management and end of life care (EOLC). There are few studies addressing follow up of patients assessed by specialist palliative care (SPC) in ED.

Aim: We aimed to examine the follow up patterns of ACP after their initial SPC consultations in the ED.

Methods: Retrospective descriptive study data was collected from electronic medical records of all ACP who attended ED from 1st march to 31st may and subsequently followed over the next 3 months. Patients who died in ED and with incomplete records were excluded. Variables recorded are demographic characteristics, diagnosis and outcomes.

Analysis: Descriptive measures with frequencies and percentages were used.

Results: 405 patients were included out of which 211-(52%) were men, 250 (61%) were on best supportive care(BSC), most frequent diagnosis were lung 72-(17.7%) ,head and neck 69-(17.1%) ,gynecological cancers 62 (15.3%). 360 were followed up after initial SPC consultation in ED.– out of which 234 (65%) were under Home care, 64 (17.7%) attended outpatient department(OPD), 42 (11.6%) Re-visited in ED and 190 (52.7%) died at home.

Conclusion: ACP who attended ED were mainly males, with lung, head and neck and gynecological malignancies most patients received BSC and EOLC. Majority patients were followed up by home care team , others revisited OPD and ED.

PP-122_94

Availability of Essential Medicine for Palliative Care in Nepal: A Cross Sectional Survey

Rajeev Shrestha, Bruce Hayes, Daniel Munday

INF Green Pastures Hospital, Pokhara, Nepal.
E-mail: rajeev.shrestha@nepal.inf.org; Mobile: 00977-9845445205
E-mail: bruce.hayes@inf.org
E-mail: daniel.munday@inf.org

Introduction: The 2017 Nepalese National Strategy for Palliative Care (NSPC) committed to universal palliative care provision within 10 years. The NSPC proposed that the International Association for Hospice and Palliative Care (IAHPC) list of Essential Medicines for Palliative Care (EMPC), consisting of 33 medicines in 62 different formulations, should be available at each level from health post (HP) to tertiary hospital. Some medicines are provided free in government healthcare sites and some have fixed cost. The Government of Nepal is developing a health insurance model for Universal Health Coverage (UHC).

Aim: To assess the extent to which EMPC are currently available in healthcare settings and within national medicinal programmes.

Methods: Cross-sectional descriptive study of the availability of EMPC in Nepal including the National Essential Medicines List (NEML), Government Health Insurance Medicines List (GHIML), Government Fixed Rate Medicines List (GFRML) and free medicines list for District Hospitals (DH), Primary Healthcare Centres (PHC) and HP.

Results: 42/62(68%) EMPC formulations are currently available in Nepal; 36/62(58%) on GHIML 28/62(45%) on NEML. 13/62(21%), 11/62(18%) and 6/62(10%) are free of cost at DH, PHC and HP respectively. Only 4/62(7%) are on the GFRML.

Conclusions: Currently only 2/3 of EMPC are available in Nepal. Very few are available free of charge in government health settings with decreasing availability through secondary to primary care. Whilst more EPCMs are available free of cost to people with health insurance. This still falls short of UHC. Work is currently ongoing to develop a robust Nepalese EMPC formulary using alternative medicines.

PP-165_148

Recovery oriented services – A popular model in mental health care: Lessons to learn for Palliative care

Dr. Divya SK[1], Dr. Hareesh Angothu[2]

[1]Senior Resident, Department of Psychiatry, NIMHANS, Bengaluru, India; [2]Consultant, Psychiatric rehabilitation Unit, Department of Psychiatry, NIMHANS, Bengaluru, India.
E-mail: divumapa3@gmail.com; Mobile: 8073128358

Introduction: Rehabilitation is an important part of any chronic illness, as is true for severe psychiatric illness. Care of patients with mental illness (PMIs) involves a large contribution by family in Indian setting. However, 'Recovery oriented services' (ROSes) embark 'autonomy' as corner stone in rehabilitation process.

Aim: To conduct a comprehensive review of existing 'Recovery oriented service' model across globe which can be adapted to palliative care setting.

Methodology: This is a narrative review on different model of recovery oriented services. We attempt to review 'components' of different models in 'RoSes' adaptable to palliative care setting. We also explore different challenges and plausible modifications relevant to adapt this rehabilitation model into palliative care.

Results: Focussing on personal recovery, with realistic hope and optimism inducted in service delivery, holistic stance with a skilled adaptable workforce and inclusion of social determinants of health and well-being. These are all the components being used in ROSes. There remains marked overlap with palliative care hence models across country for mental health service delivery still holds good for palliative care too. Challenges in adapting includes difficulty in setting personal recovery goals in a life limiting illness, limited resources, non-existent Indian model of ROSes.

Conclusion: Adapting models from other speciality with modifications according to speciality, helps address need for health care models in the country.

Preference of abstract category:

Rehabilitation theme

Requesting for oral presentation