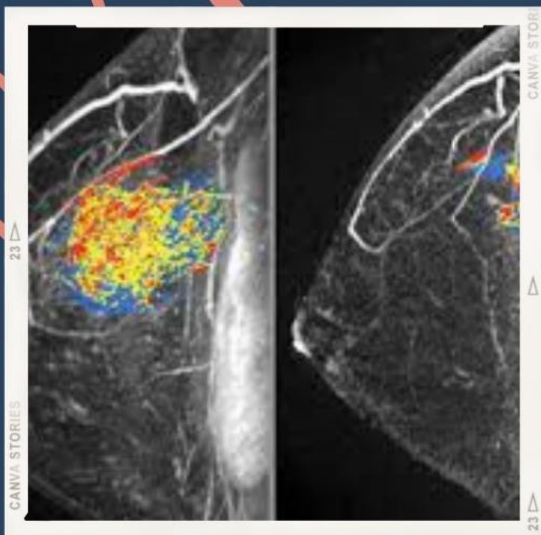


A TOUCH OF TENDER LOVING CARE

# PALLIATIVE CARE IN ADVANCED MALIGNANCIES



Dr Ranga Perera





# **Palliative Care in Advanced Malignancies**

## **A Guide for Healthcare Professionals**

**College of Palliative Medicine of Sri Lanka 2025**

**Dr Ranga Perera**

MBBS, MS, PgCert. (Med Edu). FRCS, FRCS Ed., FCSSL.

Senior Lecturer in Surgery,

Faculty of Medicine,

Consultant Oncological Surgeon

Head of Cancer Care Services

University Hospital of General Sir John Kothelawala Defence University

General Sir John Kothelawala Defence University

Sri Lanka

Cover Page design

Dr Sashiprabha Nawaratne

# **Palliative Care in Advanced Malignancies**

## **A Guide for Healthcare Professionals**

College of Palliative Medicine of Sri Lanka 2025

### **Copyright Page**

Palliative Care in Advanced Malignancies

© 2025 The College of Palliative Medicine of Sri Lanka

ISBN: 978-624-210-479-9

The material in this work is copyrighted with permission from the College of Palliative Medicine of Sri Lanka.

All other queries on rights and licenses, including subsidiary rights, should be addressed to the College of Palliative Medicine of Sri Lanka.

### **Author**

#### **Dr Ranga Perera**

MBBS, MS, PgCert. (Med Edu). FRCS, FRCS Ed. FCSL,

Senior Lecturer in Surgery & Consultant Oncological Surgeon

Faculty of Medicine,

General Sir John Kothelawala Defence University,

Sri Lanka

### **Reviewer**

#### **Prof Jayantha Balawardena**

MBBS, MD, FRCP, FRCP(Edin), FCOsL, FCPMSL

Professor in Oncology

Faculty of Medicine,

Senior Consultant Oncologist

University Hospital General Sir John Kothelawala Defence University

General Sir John Kothelawala Defence University





### **Message from the Secretary of Health and Mass Media**

I wish to extend my heartfelt congratulations to the College of Palliative Medicine of Sri Lanka on the publication of this latest volume in the series *A Touch of Tender Loving Care*. This body of work stands as a testament to the profound compassion, clinical excellence, and cultural sensitivity that define palliative and end-of-life care in our nation.

In a world often preoccupied with cure, this series gently reminds us of the healing power of presence, dignity, and empathy. It illuminates the quiet heroism of caregivers, the resilience of patients, and the sacred responsibility we bear as health professionals to walk alongside individuals and families during life's most vulnerable moments.

Sri Lanka has long upheld a tradition of holistic, community-rooted care. Through these pages, we see that tradition evolves, infused with evidence-based practice, ethical reflection, and the tender wisdom of lived experience. I commend the College for fostering a space where science and humanity meet, and where every chapter becomes a call to action for more compassionate systems, policies, and education.

May this publication inspire continued dialogue, innovation, and advocacy for palliative care not only as a medical speciality, but as a moral imperative in our pursuit of health equity and social justice.

**Dr Anil Jasinghe**

Secretary to the  
Ministry of Health and Mass Media

## **Preface**

It is with great honour and purpose that this book is presented, "Palliative Care in Advanced Malignancies." As cancer remains a leading cause of suffering and mortality worldwide, the role of palliative care has never been more crucial. This handbook is designed to serve as a practical, evidence-informed guide for all healthcare professionals involved in the care of patients with advanced malignancies.

The content of this handbook is presented from a multidisciplinary perspective, emphasising not only the management of physical symptoms but also the psychological, social, and spiritual dimensions of care. Our aim is to disseminate the knowledge of palliative care and promote its integration across the range of oncology—offering relief, dignity, and support to patients and their families when they need it most.

This publication would not have been possible without the contributions of numerous clinicians, educators, and researchers. I especially appreciate the contribution of Prof Jayantha Balawardena for dedicating his time and energy as an external reviewer. I am especially grateful to the members of the College of Palliative Medicine of Sri Lanka for their unwavering commitment to advancing the field and to every reader who continues to advocate for the holistic care of those living with and dying from cancer.

May this handbook serve not only as a clinical reference but also as a reminder of our shared humanity in the face of serious illness.

**Dr Ranga Perera**

## **Message from the President of the College of Palliative Medicine**

Palliative care, once viewed as an optional or terminal phase intervention, has now rightfully emerged as an essential component of comprehensive healthcare. For patients living with advanced malignancies, palliative care offers not only symptom relief but also psychosocial support, spiritual healing, and, above all, an endorsement of dignity and personhood throughout the course of illness.

This Handbook on "Palliative Care in Advanced Malignancies" has been developed in response to the growing need for practical, context-sensitive guidance for healthcare professionals working in oncology and other related disciplines.

The handbook is designed to be accessible, concise, and applicable across various clinical settings. It brings together contributions from experienced professionals in medicine, nursing, surgery, psychiatry, and spiritual care, ensuring a genuinely interdisciplinary approach. Each chapter reflects evidence-based best practices tailored to the challenges of real-world clinical care.

This publication is not only a reflection of academic and clinical excellence but also a tribute to the courage of patients and families facing advanced cancer. We hope that this handbook will empower clinicians to provide care that is not only scientifically sound but also deeply humane.

We extend our sincere thanks to all the contributors, reviewers, and the College of Palliative Medicine of Sri Lanka, whose vision and support have made this work possible. May this book serve as both a practical guide and a source of inspiration in the compassionate care of those with advanced malignancies.

**Dr Renuka Jayatissa**  
**President**  
**College of Palliative Medicine of Sri Lanka**



## Table of Contents

<b>Section 1: Introduction to Palliative Care</b>	1
1.1 Definition and Principles of Palliative Care	1
1.2 WHO Guidelines and Global Perspectives	2
1.3 Integration of Palliative Care in Oncology	3
1.4 Ethical and Legal Considerations	4
<b>Section 2: Assessment and Symptom Management</b>	8
2.1 Comprehensive Patient Assessment	8
2.2 Pain Management	11
2.3 Management of Common Symptoms	14
<b>Section 3: Disease-Specific Considerations</b>	20
3.1 Palliative Care in Advanced Lung Cancer	20
3.2 Palliative Care in Advanced Breast Cancer	22
3.3 Palliative Care in Gastrointestinal Cancers	24
3.4 Palliative Care in Head & Neck Cancers	26
3.5 Palliative Care in Hematologic Malignancies	28
3.6 Palliative Care in Neurological Malignancies	30
3.7 Palliative Care in Paediatric Malignancies	32
<b>Section 4: End-of-Life Care</b>	35
4.1 Recognising the End-of-Life Phase	35
4.2 Communication about Prognosis	35
4.3 Symptom Management at End of Life	35
4.4 Family Support and Preparation	36
4.5 Care After Death	36
<b>Section 5: Practical Aspects and Service Delivery</b>	38
5.1 Outpatient vs. Inpatient Palliative Care	38
5.2 Home-Based Palliative Care Services	39
5.3 Role of Multidisciplinary Teams	40
5.4 Use of Technology in Palliative Care	41
5.5 Education and Training in Palliative Oncology	42
<b>References</b>	44

# Section 1: Introduction to Palliative Care

## 1.1 Definition and Principles of Palliative Care



### Definition

Palliative care is a focused medical approach that emphasises improving the quality of life for individuals facing life-limiting illnesses, particularly through the prevention and relief of suffering. According to the World Health Organisation (WHO), palliative care is defined as:

***"An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems—physical, psychosocial, and spiritual."***

### Core Principles of Palliative Care

1. **Person-Centred Care:** Treatment plans are tailored to the individual's values, goals, and cultural context.
2. **Symptom Control:** Relief of pain and other distressing symptoms is a central aim.
3. **Psychosocial and Spiritual Support:** Care extends beyond physical needs to include psychological, social, emotional, and spiritual dimensions.
4. **Interdisciplinary Approach:** Effective palliative care requires collaboration across disciplines, including

medicine, nursing, social work, psychology, and chaplaincy.

5. **Support for Families:** Families are considered integral to the care process and receive support throughout and after the patient's illness.
6. **Continuity of Care:** Palliative care is applicable early in the course of illness and can be provided alongside curative or life-prolonging treatments.

## 1.2 WHO Guidelines and Global Perspectives

### Global Framework

The WHO has long advocated for the integration of palliative care into healthcare systems, recognising it as a human right. Key WHO documents, such as the 2014 World Health Assembly Resolution (WHA67.19), have advised the member states to reinforce palliative care **as a component of universal health coverage**.

### Key Recommendations from WHO:

- Palliative care should be integrated at all levels of health care: community, primary, secondary, and tertiary.
- It should be included in national health policies and budgets.
- Access to essential palliative care medications, especially opioids for pain relief, must be ensured.
- Training of health professionals in palliative care is vital.

## Global Trends

- High-income countries have developed structured palliative care services; however, access remains limited in many low- and middle-income countries.
- The global need for palliative care is increasing due to ageing populations and the rising burden of non-communicable diseases, including cancer.

### 1.3 Integration of Palliative Care in Oncology

#### Why Integrate?

Advanced malignancies often present with complex physical symptoms, emotional distress, and profound existential questions. Early integration of palliative care into oncology has been shown to:

- Improve symptom control and quality of life
- Reduce unnecessary hospitalisations and interventions
- Facilitate informed decision-making and goal-concordant care
- Improve caregiver outcomes

#### Models of Integration:

1. **Concurrent Model:** Palliative care is introduced at diagnosis and provided alongside disease-specific treatments.
2. **Consultative Model:** Palliative care specialists are involved upon request during cancer treatment or when symptoms become complex. (Common method used)
3. **Embedded Model:** Palliative care teams are embedded in oncology clinics or cancer centres to

provide seamless, team-based care. (The best method possible)

**Barriers to Integration:**

- Misconceptions that palliative care is only for the terminal phase
- Limited training among oncology professionals
- Inadequate service infrastructure or policy support

**Opportunities:**

- Early referrals
- Joint oncology-palliative care clinics
- Interdisciplinary case discussions

**1.4 Ethical and Legal Considerations in Palliative Care**



**Key Ethical Principles:**

1. **Autonomy:** Respecting the patient's right to make informed decisions, including the right to refuse treatment.
2. **Beneficence and Non-maleficence:** Ensuring interventions are in the patient's best interest and do not cause harm.
3. **Justice:** Fair allocation of resources and access to palliative care services.
4. **Dignity:** Upholding the inherent worth of the individual in all aspects of care.

**Common Ethical Issues:**

- Decision-making capacity – Needs to be assessed by a psychiatrist in a conscious patient.
- Withholding or withdrawing life-sustaining treatments.
  - In a Child (less than 18), consent should be taken from the Parents.
  - A competent adult patient has autonomy.
  - In an incompetent patient, it is the responsibility of the “Medical team.” Since autonomy is impossible in the context of the other three principles of Medical Ethics, the medical team needs to decide whether to withhold or withdraw treatment; the family has no authority. Only need to discuss and inform the medical team of the decision, and document it.
- Truth-telling and breaking bad news
- Advance directives and Do Not Attempt Resuscitation (DNAR) orders.

**Legal Aspects:**

Vary by country and region, but typically include:

- Consent and documentation practices
- Access to opioids and controlled substances
- Protection of patient rights and privacy
- Legal frameworks around end-of-life decisions and advance care planning

**Sri Lankan Context:**

***The laws are under review with the new Medical Ordinance of Sri Lanka. Proper documentation is vital as the laws are being prepared. Currently, problems will be handled on a case-by-case basis until the system adopts the new rules.***

**REMEMBER THE CORE PRINCIPLES OF MEDICAL ETHICS**

- 1. *Autonomy:*** Respecting the patient's right to make informed decisions, including the right to refuse treatment.
- 2. *Beneficence:*** Ensure the patient's best interest
- 3. *Non-maleficence:*** Do not cause harm
- 4. *Justice:*** Fair allocation of resources
- 5. *Dignity and Honesty:*** Upholding the inherent worth of the individual in all aspects of care.



## Section 2: Assessment and Symptom Management

### 2.1 Comprehensive Patient Assessment

#### Physical, Psychological, Social, and Spiritual Domains

A comprehensive assessment in palliative care addresses multiple domains of patient well-being. This holistic approach ensures that care plans address the full spectrum of patient needs.



#### Physical Assessment

- Evaluation of performance status (e.g., ECOG, Karnofsky scales) \*
- Symptom assessment using validated tools (e.g., ESAS, POS) \*
- Physical examination focused on symptom burden
- Review of medications and their side effects
- Nutritional assessment

#### Psychological Assessment

- Screening for depression, anxiety, and adjustment disorders
- Assessment of coping mechanisms and resilience
- Evaluation of cognitive function
- Understanding of illness and prognosis
- Existential concerns and fears

## Social Assessment

- Family structure and dynamics
- Caregiver availability and capabilities
- Financial concerns and resources
- Living situation and environment
- Cultural background and beliefs



## Spiritual Assessment

- Religious or spiritual beliefs
- Sources of meaning and hope
- Spiritual distress or concerns
- Rituals or practices important to the patient
- End-of-life beliefs and wishes

## Assessment Tools

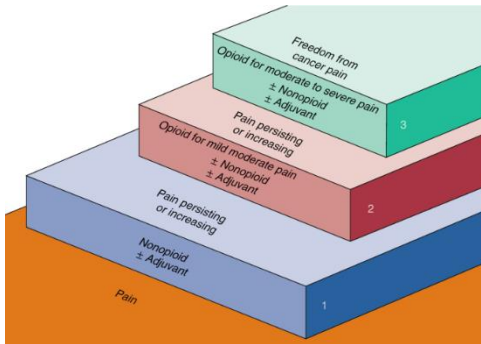
Several validated tools can facilitate a comprehensive assessment of the patient and caregiver:

- Edmonton Symptom Assessment System (ESAS)\*
- Palliative Performance Scale (PPS) Online Scale\*
- Palliative Outcome Scale (POS)\*
- Distress Thermometer
- FAMCARE Scale for family caregiver assessment\*

\*Available in the following web sites,  
<https://www.albertahealthservices.ca/frm-07903.pdf>,  
<https://eprognosis.ucsf.edu/ppp.php>,  
<https://www.mypcnow.org/fast-fact/the-palliative-performance-scale-pps>, [https://www.nccn.org/docs/default-source/patient-resources/nccn\\_distress\\_thermometer.pdf](https://www.nccn.org/docs/default-source/patient-resources/nccn_distress_thermometer.pdf),  
[http://www.npcrc.org/files/news/famcare\\_scale.pdf](http://www.npcrc.org/files/news/famcare_scale.pdf)

## 2.2 Pain Management

### WHO Analgesic Ladder



The WHO analgesic ladder provides a framework for pain management based on pain severity:

#### Step 1: Mild Pain

- Non-opioid analgesics (e.g., paracetamol, NSAIDs)
- Adjuvant analgesics as indicated

#### Step 2: Moderate Pain

- Weak opioids (e.g., codeine, tramadol)
- Continue non-opioids if appropriate
- Adjuvant analgesics as indicated

#### Step 3: Severe Pain

- Strong opioids (e.g., morphine, oxycodone, fentanyl)
- Continue non-opioids if appropriate
- Adjuvant analgesics as indicated

## ***Opioid Use and Side Effects***

### **Opioid Selection and Administration**

- Morphine remains the gold standard potent opioid
- Oral route is preferred when possible
- Immediate-release formulations for dose titration
- Modified-release formulations for stable pain
- Consider alternative routes (subcutaneous, transdermal) when oral administration is not possible

### **Opioid Side Effects and Management**

- **Constipation:** Prophylactic laxatives (e.g., stimulant + softener)
- **Nausea and vomiting:** Antiemetics (e.g., haloperidol, metoclopramide)
- **Sedation:** Usually transient; consider dose reduction or rotation if persistent
- **Cognitive impairment:** Assess for delirium; consider opioid rotation or dose reduction
- **Respiratory depression:** Rare with appropriate titration; naloxone available if needed
- **Myoclonus:** Consider opioid rotation or benzodiazepines

### **Opioid Rotation**

When side effects persist or pain control is inadequate, opioid rotation may be necessary:

- Calculate equianalgesic dose
- Reduce by 25-50% for incomplete cross-tolerance
- Reassess frequently

## Adjuvant Analgesics

Adjuvant analgesics can enhance pain control for specific pain types:

- **Neuropathic pain:** Antidepressants (e.g., amitriptyline), anticonvulsants (e.g., gabapentin, pregabalin)
- **Bone pain:** NSAIDs, corticosteroids, bisphosphonates
- **Visceral pain:** Antispasmodics, corticosteroids
- **Muscle spasm:** Benzodiazepines, baclofen

## Other Methods

Adjuvant methods of nerve stimulation and ablation have been practised and have been found helpful in many situations.

- Electrical Nerve stimulation methods
  - Transcutaneous Electrical Nerve Stimulation (TENS)
  - Peripheral Nerve Stimulation (PNS)
  - Spinal Cord Stimulation (SCS)
  - Dorsal Root Ganglion (DRG) Stimulation
- Ablative methods
  - Radiofrequency Ablation (RFA)
  - Cryoablation (Cryoneurolysis)
  - Chemical Neurolysis (Alcohol or Phenol)

Chemical Neurolysis is most used for severe cancer pain to destroy specific nerve plexuses like the trigeminal ganglion, the Celiac ganglion, etc.

## 2.3 Management of Common Symptoms

### Dyspnoea and Respiratory Symptoms

#### Assessment

- Evaluate severity, timing, and aggravating/alleviating factors
- Assess for reversible causes (e.g., infection, effusion, anaemia)
- Consider underlying disease progression

#### Management

- **Non-pharmacological:**
  - Positioning (upright)
  - Oxygen therapy if hypoxemic
  - Fan-directed air movement
  - Breathing techniques and relaxation
- **Pharmacological:**
  - Opioids (first-line for refractory dyspnoea)
  - Benzodiazepines for associated anxiety
  - Corticosteroids for airway obstruction or lymphangitis carcinomatosa
  - Bronchodilators if bronchospasm is present

### Fatigue and Weakness

#### Assessment

- Distinguish from depression or other treatable causes
- Evaluate impact on activities of daily living
- Assess for reversible factors (e.g., anaemia, metabolic disturbances)

## **Management**

- **Non-pharmacological:**
  - Energy conservation techniques
  - Graded exercise programmes
  - Occupational therapy assessment
  - Psychological support
- **Pharmacological:**
  - Corticosteroids (short-term use)
  - Psychostimulants (e.g., methylphenidate) in selected cases
  - Treatment of contributing factors (e.g., anaemia, nutritional deficiencies)

## **Anorexia and Cachexia**

### **Assessment**

- Evaluate weight loss and dietary intake
- Screen for depression and gastrointestinal symptoms
- Assess metabolic and nutritional status

### **Management**

- **Non-pharmacological:**
  - Small, frequent, high-calorie meals
  - Nutritional counselling
  - Address specific food preferences and aversions
- **Pharmacological:**
  - Corticosteroids (short-term appetite stimulation)
  - Pregestational agents (e.g., megestrol acetate)
  - Consider ghrelin agonists (e.g. Capromorelin) or cannabinoids in selected cases

## **Nausea and Vomiting**

### **Assessment**

- Identify underlying cause (e.g., biochemical, mechanical, treatment-related)
- Evaluate pattern and associated symptoms
- Assess hydration status

### **Management**

- **Pharmacological** (based on emetic pathway):
  - Dopamine antagonists (e.g., metoclopramide, haloperidol)
  - Serotonin antagonists (e.g., ondansetron)
  - Neurokinin-1 antagonists (e.g., aprepitant)
  - Corticosteroids
  - Antihistamines and anticholinergics

## **Constipation and Bowel Obstruction**

### **Constipation Assessment and Management**

- Evaluate medication causes (e.g., opioids, anticholinergics)
- Assess fluid intake, mobility, and dietary factors
- Regular bowel regimen with stimulant and softening laxatives
- Consider opioid rotation if opioid-induced

### **Bowel Obstruction Assessment and Management**

- Distinguish between complete and partial obstruction

- **Non-pharmacological:**
  - Nil by mouth status or minimal liquids
  - Venting gastrostomy in selected cases
- **Pharmacological:**
  - Antisecretory agents (e.g., octreotide, anticholinergics)
  - Antiemetics
  - Analgesics (including opioids)
  - Corticosteroids to reduce oedema
- **Surgical Intervention**
  - Stenting
  - Bypass
  - Stoma creation

## **Delirium and Confusion**

### **Assessment**

- Use validated screening tools (e.g., CAM<sup>1</sup>, MMSE<sup>2</sup>)
- Identify potential precipitants (e.g., medications, metabolic disturbances, infection)
- Distinguish from dementia and depression

## Management

- **Non-pharmacological:**
  - Environmental modifications (e.g., quiet room, familiar objects)
  - Reorientation strategies
  - Family involvement
- **Pharmacological:**
  - Antipsychotics (e.g., haloperidol, quetiapine)
  - Benzodiazepines only for **alcohol withdrawal or severe agitation**
  - Treat underlying causes when possible

## Depression and Anxiety

### Assessment

- Use screening tools (e.g., PHQ-9, GAD-7)<sup>1</sup>
- Distinguish from adjustment disorder, demoralisation, and grief
- Evaluate for suicidal ideation

### Management

- **Non-pharmacological:**
  - Psychological therapies (e.g., CBT, supportive therapy)
  - Pet therapy
  - Music therapy
  - Art therapy
  - Meaning-centred interventions
  - Family support and education

- **Pharmacological:**
  - SSRIs or SNRIs (first-line)
  - Mirtazapine if insomnia or weight loss is prominent
  - Psychostimulants for severe cases with a limited prognosis
  - Benzodiazepines are only for short-term anxiety management

## Section 3: Common Disease-Specific Considerations

### 3.1 Palliative Care in Advanced Lung Cancer



#### Common Symptoms and Challenges

- Dyspnoea (often multifactorial)
- Cough (dry or productive)
- Haemoptysis
- Chest pain
- Superior vena cava obstruction
- Pleural effusions

#### Disease-Specific Management Approaches

##### Dyspnoea Management

- Oxygen therapy for hypoxemic patients
- Opioids for refractory dyspnoea
- Consider anxiolytics for associated anxiety
- Pulmonary rehabilitation techniques

##### Cough Management

- Identify and treat reversible causes (e.g., infection)
- Peripheral antitussives (e.g., levodropropizine)
- Central antitussives (e.g., codeine, morphine)
- Consider inhaled medications for specific causes

### **Haemoptysis Management**

- Reassure patient and family
- Identify source and severity
- Consider radiotherapy or bronchial artery embolisation for significant bleeding
- Antifibrinolytics (e.g., tranexamic acid) in selected cases

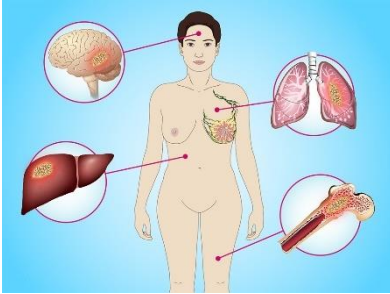
### **Superior Vena Cava Obstruction**

- Corticosteroids to reduce oedema
- Consider urgent radiotherapy or stent placement
- Elevate the head of the bed
- Symptomatic management of headache and facial swelling

### **Pleural Effusions**

- Therapeutic thoracentesis for symptomatic relief
- Consider an indwelling pleural catheter or pleurodesis for recurrent effusions
- Oxygen therapy if hypoxemic

### 3.2 Palliative Care in Advanced Breast Cancer



#### Common Symptoms and Challenges

- Bone pain and pathological fractures
- Hypercalcaemia
- Lymphoedema
- Skin involvement and ulceration

#### Disease-Specific Management Approaches

##### Bone Metastases

- Analgesics following the WHO ladder
- NSAIDs for bone pain
- Bisphosphonates or denosumab to prevent skeletal events
- Consider radiotherapy for localised pain or high fracture risk
- Orthopaedic consultation for impending or actual fractures

##### Hypercalcaemia

- Aggressive hydration
- Bisphosphonates or denosumab
- Consider calcitonin in severe cases
- Monitor renal function and electrolytes

##### Lymphoedema

- Compression garments

- Manual lymphatic drainage
- Skin care to prevent infection
- Physiotherapy exercise and elevation
- Psychological support for body image concerns

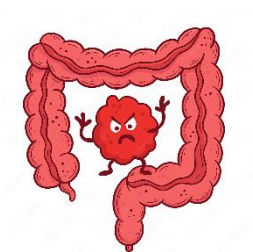
### **Skin Ulceration**

- Mastectomy if possible
- Meticulous wound care
- Control odour (e.g., metronidazole gel)
- Manage exudate (e.g., alginate dressings)
- Consider radiotherapy for bleeding or fungating lesions
- Address psychosocial impact

### **Psychological Support**

- Counselling for body image concerns
- Support groups
- Prosthesis fitting when appropriate
- Sexual health counselling

### 3.3 Palliative Care in Advanced Gastrointestinal Cancers



#### Common Symptoms and Challenges

- Malignant bowel obstruction
- Ascites
- Jaundice and pruritus
- Malnutrition and cachexia
- Fistula formation

#### Disease-Specific Management Approaches

##### Malignant Bowel Obstruction

- Assess for complete vs. partial obstruction
- NPO status or minimal liquids
- Octreotide to reduce secretions
- Antiemetics (e.g., Ondansetron, haloperidol, levomepromazine)
- Consider **venting gastrostomy** (Draining gastrostomy)
- Corticosteroids to reduce oedema

##### Ascites

- Therapeutic paracentesis for symptomatic relief
- Consider an indwelling drain for recurrent ascites
- Diuretics if appropriate (e.g., in peritoneal carcinomatosis with liver metastases-Spironolactone)
- Salt restriction

##### Jaundice and Pruritus

- Biliary stenting for obstructive jaundice
- Ursodeoxycholic acid for pruritus
- Antihistamines for mild pruritus
- Consider opioid antagonists (e.g., naloxone infusion) or serotonin antagonists for refractory pruritus

## **Malnutrition**

- Dietary counselling and modification
- Enteral feeding **when appropriate**
- Consider parenteral nutrition in **selected cases**
- Appetite stimulants (e.g., corticosteroids, megestrol)
- Address specific symptoms affecting nutrition (e.g., nausea, early satiety)

## **Fistula Management**

- Protect surrounding skin with barrier products (ZnO<sub>2</sub>)
- Use appropriate wound collection devices
- Control odour with topical metronidazole or charcoal dressings
- Consider surgical intervention in selected cases
- Antibiotics for localised infection

### **3.4 Palliative Care in Head & Neck Cancers**

#### **Common Symptoms and Challenges**

- Pain (often neuropathic)
- Dysphagia and odynophagia
- Bleeding from the tumour/Nodes
- Airway compromise
- Communication difficulties
- Disfigurement and body image concerns

#### **Disease-Specific Management Approaches**

##### **Pain Management**

- Opioids following the WHO ladder
- Adjuvant analgesics for neuropathic pain (e.g., gabapentin, amitriptyline)
- Consider nerve blocks for refractory pain
- Topical agents for localised pain (e.g., lidocaine gel)

##### **Dysphagia and Odynophagia**

- Dietary modification (e.g., soft foods, liquids)
- Enteral feeding when necessary
- Analgesics before meals
- Treat oral candidiasis and other infections
- Saliva substitutes for xerostomia (e.g. carboxymethylcellulose, hydroxyethylcellulose)

##### **Bleeding from the tumour/Nodes**

- Regular dressings
- Adrenaline dressings
- Surgical intervention (e.g. Ligation, clipping)
- Major bleeds (Carotid blowouts – shunting or ligation)

**Airway Management**

- Assess for stridor and respiratory distress
- Consider tracheostomy for significant obstruction
- Corticosteroids to reduce oedema
- Humidified oxygen
- Emergency airway equipment readily available

**Communication Support**

- Speech therapy assessment
- Alternative communication methods (e.g., writing boards, electronic devices)
- Address the psychological impact of communication loss
- Family education on communication techniques

**Psychosocial Support**

- Counselling for body image concerns
- Prosthesis consultation when appropriate
- Support groups
- Psychological therapy for depression and anxiety

### 3.5 Palliative Care in Haematologic Malignancies



#### Common Symptoms and Challenges

- Bone marrow failure (anaemia, neutropenia, thrombocytopenia)
- Infections
- Bleeding complications
- Graft-versus-host disease (in transplant patients)
- Rapid disease progression

#### Disease-Specific Management Approaches

##### Bone Marrow Failure

- Transfusion support for symptomatic anaemia and thrombocytopenia
- Growth factors in selected cases
- Antibiotic and antifungal prophylaxis for neutropenia
- Symptomatic management of fatigue

##### Infection Management

- Early recognition and aggressive treatment
- Consider both bacterial and fungal pathogens
- Antiviral prophylaxis and treatment when indicated
- Granulocyte colony-stimulating factors in selected cases

##### Bleeding Complications

- Platelet transfusions for significant bleeding or very low counts

- Antifibrinolytics (e.g., tranexamic acid) for mucosal bleeding
- Avoid invasive procedures when possible
- Topical agents for accessible bleeding sites

### **Graft-versus-Host Disease**

- Immunosuppressive therapy
- Symptomatic management of skin, gastrointestinal, and hepatic involvement
- Nutritional support
- Psychological support for complex treatment burden

### **End-of-Life Considerations**

- Clear communication about prognosis and goals of care
- Balance disease-modifying treatments with symptom control
- Address potential for rapid deterioration
- Support for complex decision-making regarding continued treatment

### 3.6 Palliative Care in Neurological Malignancies



#### Common Symptoms and Challenges

- Headache and increased intracranial pressure
- Seizures
- Focal neurological deficits
- Cognitive impairment
- Communication difficulties

#### Disease-Specific Management Approaches

##### Headache and Increased Intracranial Pressure

- Corticosteroids (e.g., dexamethasone) to reduce oedema
- Elevate the head of the bed
- Opioids for pain control
- Consider mannitol or hypertonic saline (3%) for severe cases
- Avoid medications that may worsen cognitive function

##### Seizure Management

- Prophylactic anticonvulsants for high-risk patients
- Rescue medication for breakthrough seizures (e.g., buccal midazolam)
- Regular review of anticonvulsant therapy
- Education for the family on seizure management

##### Focal Neurological Deficits

- Rehabilitation therapies (physiotherapy, occupational therapy, speech therapy)

- Adaptive equipment and environmental modifications
- Prevention of complications (e.g., contractures, pressure injuries)
- Psychological support for loss of function

### **Cognitive Impairment**

- Regular cognitive assessment
- Environmental modifications to support orientation
- Family education on cognitive changes
- Medication review to minimise psychoactive effects
- Consider acetylcholinesterase inhibitors in selected cases

### **Communication Support**

- Speech therapy assessment
- Alternative communication methods
- Augmentative and alternative communication devices
- Family education on communication techniques

### 3.7 Palliative Care in Paediatric Malignancies

#### Common Symptoms and Challenges

- **Pain** (often under-recognised in non-verbal children)
- **Nausea/vomiting** (chemotherapy-related)
- **Fatigue** (impacting play/development)
- **Anxiety/fear** (procedures, separation)
- **Communication barriers** (age/developmental stage)
- **Family distress** (parental guilt, sibling needs)
- **Ethical complexities** (treatment withdrawal decisions)

#### Disease-Specific Management Approaches

##### Pain Assessment & Management

[Image: Cartoon showing a nurse using the FLACC scale (Face, Legs, Activity, Cry, Consolability) with a toddler. Pain chart with smiley/frowny faces visible.]

- **Age-appropriate tools:** FLACC<sup>1</sup> scale (<3 yrs), Wong-Baker FACES<sup>2</sup> (3+ yrs), self-report (adolescents)
- **Pharmacological:** (WHO Ladder for the weight)
  - Paracetamol/NSAIDs (mild pain)
  - Weak opioids (e.g., codeine liquid) for moderate pain
  - Strong opioids (e.g., oral morphine solution) for severe pain
  - *Always calculate doses by weight (mg/kg)*

1. <http://www.childcancerpain.org/content.cfm?content=assess08>

2. <https://wongbakerfaces.org/>

- **Non-pharmacological:**
  - Play therapy, distraction techniques
  - Heat/cold packs, massage
  - Positioning for comfort

### **Nausea & Vomiting**

- **Pre-emptive antiemetics:** Ondansetron (first-line)
- **Rescue:** Metoclopramide, prochlorperazine
- **Non-drug:** Acupressure bands, ginger sweets, small, frequent meals
- **Psychological support:** Medical play therapy to reduce procedure-related anxiety

### **Fatigue & Activity Limitation**

- **Energy conservation:** Pacing activities, scheduled rest
- **Adaptive play:** Seated art projects, tablet-based games
- **School integration:** Home tutoring, virtual classroom access
- **Family education:** Balancing activity with rest periods

### **Psychosocial Support**

- **Child-focused interventions:**
  - Play/art therapy for emotional expression
  - Age-appropriate information about illness
  - Memory-making activities (handprints, voice recordings)

- **Family support:**
  - Parental counselling for anticipatory grief
  - Sibling support groups
  - Respite care coordination
  
- **Cultural considerations:**
  - Respect family beliefs about discussing death with children
  - Involve extended family in care planning

## **End-of-Life Care**

### **Symptom control:**

- Subcutaneous syringe drivers for continuous medication
- Anticholinergics (e.g., hyoscine) for secretions
- Benzodiazepines for terminal agitation
  
- **Family preparation:**
  - Honest, age-appropriate communication about dying
  - Creation of memory boxes<sup>1</sup>
  - Support for cultural/religious rituals
  
- **Bereavement follow-up:**
  - Counselling for parents/siblings
  - Annual memorial services
  - Peer support networks

## **Section 4: End-of-Life Care**

### **4.1 Recognising the End-of-Life Phase**

#### **Clinical Indicators**

- Increasing functional decline
- Reduced oral intake and swallowing difficulties
- Changes in consciousness level
- Decreased interest in surroundings
- Physiological changes (e.g., mottling, decreased urine output)

### **4.2 Communication about Prognosis**

- Honest and compassionate communication
- Preparation for the dying process
- Addressing hopes and fears
- Setting realistic expectations
- Supporting decision-making

### **4.3 Symptom Management at End of Life**

#### **Common Symptoms and Management**

- **Pain**
  - Regular opioid administration
  - Consider continuous subcutaneous infusion
  - Adjuvant analgesics as needed
  - Non-pharmacological approaches
- **Agitation and Delirium**
  - Identify and treat reversible causes when appropriate
  - Antipsychotics (e.g., haloperidol, levomepromazine)

- Benzodiazepines for terminal restlessness
- Environmental modifications
- **Respiratory Secretions ("Death Rattle")**
  - Positioning
  - Anticholinergic medications (e.g., hyoscine hydrobromide)
  - Reassurance for family
  - Gentle suctioning if appropriate
- **Breathlessness**
  - Opioids
  - Oxygen if hypoxemic
  - Positioning
  - Fan for air movement
  - Anxiolytics if anxiety is present

#### **4.4 Family Support and Preparation**

##### **Preparing Family for the Dying Process**

- Education about the physical changes of dying
- Guidance on what to expect
- Encouraging presence and participation
- Addressing cultural and religious practices
- Supporting children and adolescents

##### **4.5 Care After Death**

- Confirming death
- Providing time for family with the body
- Cultural and religious considerations
- Practical and administrative arrangements
- Initial bereavement support

It is much better if the patient has an Advanced Care Plan; the healthcare team can then discuss the Goals of care in accordance with it.

Advance Care Planning (ACP) is the process of clarifying a patient's personal values and future healthcare wishes. At the same time, Goals of Care (GOC) discussions focus on current treatment decisions based on those values.

### **The Relationship Between ACP and GOC**

- **Complementary Processes:**

ACP is the broader planning process, and GOC discussions are a vital, specific component that happens in the present.

- **Future vs. Present:**

ACP looks to the future, anticipating potential future health crises, while GOC addresses the present situation and its likely course.

- **Shared Goal:**

Both aim to ensure that the patient's medical care is consistent with their personal values, wishes, and goals.

## **Section 5: Practical Aspects and Service Delivery**

### **5.1 Outpatient vs. Inpatient Palliative Care**

#### **Outpatient Palliative Care**

- **Settings**
  - Hospital outpatient clinics
  - Community health centres
  - Day hospice programmes
- **Advantages**
  - Allows patients to remain at home
  - Maintains normalcy and routine
  - Family involvement in care
  - Cost-effective
- **Challenges**
  - Limited resources for complex care
  - Family caregiver burden
  - Access to emergency interventions
  - Travel for frail patients

#### **Inpatient Palliative Care**

- **Settings**
  - Dedicated palliative care units
  - Hospice inpatient units
  - Acute hospital wards
  - Nursing homes with palliative care expertise
- **Advantages**
  - 24/7 professional care availability
  - Management of complex symptoms

- Respite for family caregivers
- Interdisciplinary team access
- **Challenges**
  - Higher costs
  - Potential for institutionalisation
  - Limited bed availability
  - Separation from home environment

## **5.2 Home-Based Palliative Care Services**

### **Components of Home-Based Care (Need to develop in Sri Lanka)**

- **Clinical Care**
  - Symptom assessment and management
  - Medication adjustments
  - Wound care
- **Psychosocial Support**
  - Counselling
  - Family meetings
  - Bereavement preparation
  - Practical assistance
- **Coordination of Services**
  - Linkage with community resources
  - Coordination with primary care
  - Volunteer services
  - Respite care arrangements

### **Developing Home-Based Services**

- Assessment of community needs
- Training of community healthcare workers
- Development of referral systems
- Medication availability and delivery systems
- Emergency response protocols

### **5.3 Role of Multidisciplinary Teams**

#### **Core Team Members**

- **Physicians**
  - Palliative medicine specialists
  - General practitioners with palliative care training
  - Medical oncologists
  - Other specialists as needed
- **Nurses**
  - Palliative care nurse specialists
  - Community nurses
  - Practice nurses
  - Nurse practitioners
- **Allied Health Professionals**
  - Physiotherapists
  - Occupational therapists
  - Speech and language therapists
  - Dietitians
  - Pharmacists
  - Psychologists
  - Social workers

- **Support Services**
  - Spiritual care providers (Religious places)
  - Volunteers

### **Team Functioning**

- Regular team meetings
- Shared care planning
- Clear communication channels
- Defined roles and responsibilities
- Collaborative decision-making

## **5.4 Use of Technology in Palliative Care**

### **Telemedicine Applications**

- **Clinical Consultations**
  - Video consultations for routine follow-up
  - Telephone support for urgent issues
  - Specialist consultations for rural areas
  - Interprofessional team meetings
- **Symptom Monitoring**
  - Remote symptom tracking
  - Electronic patient-reported outcomes
  - Automated alerts for worsening symptoms
  - Medication management apps
- **Education and Support**
  - Online educational resources
  - Virtual support groups
  - Caregiver training videos
  - Professional development courses

### **Implementation Considerations**

- Technology access and literacy
- Privacy and security concerns
- Integration with existing systems
- Training for healthcare providers
- Cultural appropriateness

## **5.5 Education and Training in Palliative Oncology**

### **Core Palliative Care Skills**

- Communication skills
- Symptom assessment and management
- Psychosocial support
- Ethical decision-making
- End-of-life care

### **Training Approaches**

- **Undergraduate Education**
  - Integration into medical and nursing curricula
  - Clinical placements in palliative care
  - Interprofessional education
- **Postgraduate Training**
  - Speciality training programmes
  - Fellowships in palliative care
  - Continuing professional development
  - Distance learning opportunities
- **Community Education**
  - Training for primary care teams
  - Community health worker programmes
  - Family caregiver education
  - Public awareness campaigns

## **Educational Resources**

- Guidelines and protocols
- Case-based learning materials
- Simulation training
- Mentorship programmes
- Online learning platforms

## References

1. World Health Organisation. (2014). Strengthening of Palliative Care as a Component of Integrated Treatment throughout the Life Course. *Journal of Pain & Palliative Care Pharmacotherapy*, 28(2), 130–134.  
<https://doi.org/10.3109/15360288.2014.911801>
2. United Nations Human Rights Council. Resolution 26/14: Access to Palliative Care. Geneva: UN; 2014.
3. Knaul FM, Farmer PE, Krakauer EL, et al. Alleviating the Access Abyss in Palliative Care and Pain Relief—An Imperative of Universal Health Coverage: The Lancet Commission Report. *Lancet*. 2018;391(10128):1391–1454.
4. Temel, J. S., Greer, J. A., Muzikansky, A., et al. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*, 363(8), 733-742. DOI: 10.1056/NEJMoa1000678
5. Worldwide Hospice Palliative Care Alliance. *Global Atlas of Palliative Care*, 2nd Edition. WHPCA & WHO, 2020.
6. Wiffen PJ, Wee B, Derry S, Bell RF, Moore RA. Opioids for cancer pain - an overview of Cochrane reviews. *Cochrane Database Syst Rev*. 2017 Jul 6;7(7): CD012592. doi: 10.1002/14651858.CD012592.pub2. PMID: 28683172; PMCID: PMC6483487.
7. Fallon M, Giusti R, Aielli F, Hoskin P, Rolke R, Sharma M, Ripamonti CI; ESMO Guidelines Committee. Management of cancer pain in adult patients: ESMO Clinical Practice Guidelines. *Ann Oncol*. 2018 Oct 1;29(Suppl 4):iv166-iv191. doi: 10.1093/annonc/mdy152. PMID: 30052758.

8. Kaasa, S., Loge, J. H., Fayers, P., et al. (2018). Symptom assessment in palliative care: a systematic review of methodological issues and applications. *Lancet Oncology*, 19(1), e22-e37. 2018 Nov;19(11):e588-e653. doi: 10.1016/S1470-2045(18)30415-7. Epub 2018 Oct 18. PMID: 30344075.
9. Gaertner J, Siemens W, Meerpohl et al. Effect of specialist palliative care services on quality of life in adults with advanced incurable illness in hospital, hospice, or community settings: systematic review and meta-analysis. *BMJ*. 2017 Jul 4;357:j2925. doi: 10.1136/bmj.j2925.
10. Ferrell BR, Temel JS, Temin S, et al. Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update. *J Clin Oncol*. 2017 Jan;35(1):96-112. doi: 10.1200/JCO.2016.70.1474. Epub 2016 Oct 28.
11. Kaasa S, Loge JH, Fayers P, Caraceni A, Strasser F, Hjermstad MJ, Higginson I, Radbruch L, Haugen DF. Symptom assessment in palliative care: a need for international collaboration. *J Clin Oncol*. 2008 Aug 10;26(23):3867-73. doi: 10.1200/JCO.2007.15.8881. PMID: 18688054.
12. Treillet E, Laurent S, Hadjiat Y. Practical management of opioid rotation and equianalgesia. *J Pain Res*. 2018;11:2587-2601 <https://doi.org/10.2147/JPR.S170269>
13. Caraceni, A., Hanks, G., Kaasa, S., et al. (2012). Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC. *Lancet Oncol*. 2012 Feb;13(2):e58-68. doi: 10.1016/S1470-2045(12)70040-2. PMID: 22300860.

14. NICE. (2019). Care of dying adults in the last days of life. NICE Guideline [NG31]. National Institute for Health and Care Excellence. <https://www.nice.org.uk/guidance/ng31>
15. Hui, D., & Bruera, E. (2016). Integrating palliative care into the trajectory of cancer care. *Nat Rev Clin Oncol*. 2016 Mar;13(3):159-71. doi: 10.1038/nrclinonc.2015.201. Epub 2015 Nov 24. PMID: 26598947; PMCID: PMC4772864.
16. Pastrana T, Vallath N, Mastrojohn J, Namukwaya E, Kumar S, Radbruch L, Clark D. Disparities in the contribution of low- and middle-income countries to palliative care research. *J Pain Symptom Manage*. 2010 Jan;39(1):54-68. doi: 10.1016/j.jpainsymman.2009.05.023. Epub 2009 Nov 4.
17. Kavalieratos, D., Corbelli, J., Zhang, D., et al. (2016). Association between palliative care and patient and caregiver outcomes: a systematic review and meta-analysis. *JAMA*. 2016 Nov 22;316(20):2104-2114. doi: 10.1001/jama.2016.16840. PMID: 27893131; PMCID: PMC5226373.EI
18. Rajagopal MR, Kumar S. A model for delivery of palliative care in India--the Calicut experiment. *J Palliat Care*. 1999 Spring;15(1):44-9. PMID: 10333664.
19. Jawahri, A., Greer, J. A., & Temel, J. S. (2017). Does palliative care improve outcomes for patients with incurable illness? A review of the evidence. *Journal of Supportive Oncology*, 2011 May-Jun;9(3):87-94. doi: 10.1016/j.suponc.2011.03.003. PMID: 21702398.
20. Hui, D., Kim, S. H., Roquemoire, J., et al. (2020). Impact of timing and setting of palliative care referral on quality of end-of-life care in cancer patients. *Cancer*. 2014 Jun

1;120(11):1743-9. doi: 10.1002/cncr.28628. PMID: 24967463; PMCID: PMC4073257.

21. Twycross A. Optimising palliative and end-of-life care within care home settings. *Evidence-Based Nursing*. 2015 Dec 15. doi: 10.1136/eb-2015-102280
22. David Clark, Fiona Graham, Carlos Centeno, Changes in the world of palliative care, *Medicine*, Volume 43, Issue 12, 2015, Pages 696-698, ISSN 1357-3039, <https://doi.org/10.1016/j.mpmed.2015.09.012>.





**FOR FURTHER TECHNICAL ASSISTANCE PLEASE CONTACT:  
COLLEGE OF PALLIATIVE MEDICINE OF SRI LANKA  
NO.06 WIJERAMA HOUSE  
WIJERAMA MAWATHA,  
COLOMBO 07  
TP: 076 5469982  
EMAIL : OFFICECPMSL@GMAIL.COM  
WEB: WWW.CPMSL.LK**

ISBN : 978-624-210-479-9  
9 786242 104799

