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ZAPORIZHZHIA STATE MEDICAL AND PHARMACEUTICAL UNIVERSITY
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AND INTERNAL DISEASES

PALLIATIVE AND HOSPICE CARE IN THE PRACTICE OF FAMILY DOCTOR

STUDY GUIDE

for 6th studying-year students
speciality «Medicine»



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P 17 **Palliative and Hospice Care in the Practice of Family Doctor**: study guide for the practical classes and individual work for 6th-years students (speciality «Medicine»), discipline «General practice – family medicine» / N. S. Mykhailovska, A. V. Grytsay, S. M. Manujlov [et al.]. – Zaporizhzhia: ZSMPhU, 2026. – 104 p.

This study guide for practical classes and independent work for sixth- year students has been prepared in accordance with the curriculum of the academic discipline “General Practice – Family Medicine” for the specialities “Medicine”. The guide presents the general principles of palliative and hospice care within the practice of the family doctor.

Its purpose is to support students in mastering the material during independent study, preparing for practical classes and the final module assessment, and it may be used in the educational process when studying the discipline “General Practice – Family Medicine”.

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PREFACE

Modern population health in Ukraine is characterised by significant population ageing and an increasing burden of incurable diseases with a prolonged chronic course across all age groups (cardiovascular and neuropsychiatric diseases, traumatic and degenerative lesions of the brain and spinal cord, disorders of the peripheral nervous system and musculoskeletal system, tuberculosis), as well as a rising level of childhood disability. In addition, one of the most serious medico- social problems in the country is malignant neoplasms, which cause the death of more than 90,000 of our citizens each year (35% of whom are of working age). Considerable concern is also caused by the spread of HIV infection in Ukraine, which has reached epidemic proportions, with AIDS- related mortality continuing to rise. Thus, in January 2026 there are approximately 137,000 people living with HIV under medical supervision in Ukraine, and 917 people died from AIDS in 2025. These conditions frequently lead to the development of severe clinical states accompanied by impairment of basic physical, psychological, and social functions, resulting in patient suffering due to a wide range of extremely painful subjective symptoms and profound functional disturbances. According to national experts, more than 500,000 such patients in the final period of life require professional palliative and hospice care (hereafter PHC), and given the current trends in public health, the need for this type of care will continue to grow. PHC is also essential for the relatives of an incurable patient, whose presence in the family often causes severe psychological trauma to all family members and leads to social and economic disruption of family functioning, significantly reducing quality of life.

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This study guide was developed in accordance with the syllabus for the course General Practice – Family Medicine for specialties “Medicine”. Its creation was prompted by the lack of textbooks and teaching materials that fully correspond to the core sections of the General Practice – Family Medicine curriculum. The publication is recommended for students of higher medical institutions (Level IV accreditation), interns, general practitioners in family medicine, and specialists from various medical fields.

PALLIATIVE AND HOSPICE CARE IN THE PRACTICE OF FAMILY DOCTOR

I. Relevance of the Topic

Palliative care is an approach implemented at various levels of medical and social support, aimed at improving the quality of life of patients and their families who are facing life- threatening illness. This goal is achieved through the prevention and relief of suffering by means of early identification, thorough assessment, and management of pain and other severe physical symptoms, as well as the provision of psychosocial and spiritual support. This is the definition of palliative care adopted in WHO documents.

The task of palliative care is not only to alleviate the suffering of patients, but also to provide every person with a life- limiting illness and their family with the opportunity to make choices that allow them to maintain the highest possible level of activity and quality of life until the end. Achieving these aims requires efforts that lead to changes in the organisational and methodological approaches to providing medical care for people suffering from life- threatening diseases.

According to WHO experts, of the 20 million people worldwide who require palliative care at the end of life, 67% are elderly or very elderly patients, and 6% are children.

The relevance of this topic stems from the fact that palliative care is an integral component of healthcare. Globally, the proportion of incurable patients, regrettably, continues to rise. It is the responsibility of the state and society to ensure that individuals with incurable illnesses receive the necessary conditions to improve their quality of life.

In Ukraine, the need for high- quality palliative care is increasing. More than 600,000 patients require comprehensive support from various medical specialists. Their family members also require guidance and support. According to approximate estimates, more than 1.5 million people in Ukraine require palliative care each year.

These include patients with cancer, HIV/AIDS, diabetes mellitus, and other diseases. According to WHO criteria, the minimum required provision is 100

palliative- care beds per 1 million population. The situation in Ukraine still does not meet these standards.

At the same time, patients, healthcare professionals, and civil- society advocates note that over the past five years there has been an improvement in palliative care in Ukraine. New hospices and specialised units have been established; access to pain relief has expanded and improved (including the introduction of oral morphine); legislative changes have been implemented allowing the prescription of strong analgesics; and volunteer support for palliative patients is gradually developing.

A hospice is one form of palliative care - a specialised medical institution providing care for incurable patients at the end of life. The philosophy of hospice care emphasises that a hospice is not a “house of death” but a “house of life”. As of the end of 2025, Ukraine had more than 1,300 palliative care providers (inpatient + mobile) and almost 766 institutions/providers with NHSU contracts.

Palliative and hospice care has been included among the healthcare services fully funded by the state. However, the resources allocated by the government remain extremely insufficient for this category of patients. During the reform of the secondary level of healthcare, the National Health Service of Ukraine (NHSU) improved the funding of palliative and hospice care in recent years.

The Ministry of Health of Ukraine adopted the Order “On Improving the Organisation of Palliative Care in Ukraine” dated 4 June 2020, No. 1308. It is aimed at establishing a modern system for organising the provision of palliative medical care for adults and children.

Palliative- care units are being opened in smaller towns, which means that palliative care is becoming more accessible to patients.

II. Aim of Study

- to develop a comprehensive set of knowledge, skills, and competencies in palliative and hospice care;
- to learn to synthesise the acquired knowledge of PHC and interpret its application in future professional practice;

- to acquire the practical skills and abilities in palliative and hospice care necessary for the professional activity of a doctor.

III. Main Learning Objectives

Students should know:

- the development and evolution of the hospice movement and the concept of palliative care
- definitions of palliative and hospice care (PHC) and the evolution of related perspectives
- the essence, principles, and components of PHC
- the philosophy of PHC
- the concept of the dying process (its phases) and of death
- the definition of an "incurable disease"
- the characteristics of an incurable patient
- the concept of quality of life for a patient with an incurable illness and for their relatives
- methods of communication with an incurable patient and their family
- organisational forms of PHC
- the concept of pain management and the management of other debilitating symptoms
- principles of the multidisciplinary approach in PHC
- psychological and spiritual aspects of PHC
- ethical and legal issues in PHC
- the concept of burnout syndrome and methods of its prevention.

Students should be able to:

- diagnose an incurable disease, recognise the terminal state and its phases
- diagnose and treat pain syndrome using a wide range of modern analgesic techniques
- diagnose and manage other debilitating symptoms (vomiting, dyspnoea, etc.) accompanying incurable conditions
- calculate analgesic doses and write appropriate prescriptions

- maintain records and store controlled and narcotic substances in accordance with current legislation
- perform resuscitation measures for incurable patients
- provide psychological support to incurable patients and their relatives during illness and bereavement
- apply legal and ethical rules regarding the handling of a deceased person
- adhere to bioethical and legal standards when providing PHC
- counsel incurable patients and their families on medical and non- medical aspects of care during incurable illness, including issues of care, nutrition, social, legal, and spiritual support
- work effectively within a multidisciplinary team
- apply methods for preventing burnout syndrome and managing its consequences

IV. Final Learning Objectives:

to master the theoretical foundations and modern principles of palliative and hospice medicine, and to acquire knowledge of palliative and hospice care within the professional competence of the family doctor.

V. Methodological Guidelines for Practical Classes

At the beginning of the class, an initial test is conducted to assess baseline knowledge, followed by questioning on the topic of the session. Under the supervision of the instructor, students participate in a clinical review of thematic patients (case histories), with detailed discussion of the diagnosis and differential diagnosis using a syndromic approach, as well as the main diagnostic methods, principles of treatment, and the provision of emergency care in the event of complications.

Students are also offered clinical problem- solving tasks. A summary report on the topic of the session, accompanied by an appropriate presentation, is delivered. At the end of the class, a final test is administered to assess students' knowledge. The instructor answers any questions that arose during the session.

TEST QUESTIONS FOR EVALUATING BASELINE KNOWLEDGE

1. Indications for admitting oncology patients to palliative- care wards include:

A. Severe pain syndrome, impairment of motor and higher mental functions

B. Complications arising after specialised antitumour treatment

C. Pronounced pain syndrome

D. Administration of the next stage of radical treatment

E. Corrective therapy following surgical treatment

2. Tasks of a palliative- care centre:

A. Providing consultations and training relatives in caring for oncology patients with persistent physical and/or mental impairments

B. Comprehensive support for oncology patients, selection of therapy, addressing social issues, providing spiritual support, and conducting consultations

C. Addressing social issues for relatives caring for a patient at home

D. Training middle and junior medical staff in providing care for incurable oncology patients

E. A set of measures aimed at treating the oncology patient

3. The aims of palliative care in oncology are:

A. Helping the patient develop indifference to life

B. Relief of suffering in oncology patients

C. Philosophical study of oncology problems

D. Assistance in resolving social issues

E. Conducting radical treatment

4. Categories of people who require palliative care:

A. Oncology patients for whom primary treatment has been ineffective

B. Individuals suffering from alcoholism

C. Ill individuals who have lost their means of subsistence

D. Patients with severe pain syndrome, impaired motor and higher mental functions

E. Patients undergoing staged antitumour treatment

5. A drug used for severe cancer- related pain:

A. Desomorphine

B. Heroin

C. Morphine

D. Panangin

E. Paracetamol

6. How do patients usually enter a hospice?

A. By referral from the attending oncologist at the cancer centre or district oncologist at their place of residence

B. They come on their own

C. Through emergency hospital admission

D. On the recommendation of acquaintances

E. Through social- service agencies

7. Palliative treatment is a branch of:

A. Dentistry

B. Surgery

C. Oncology

D. Traumatology

E. Neurology

8. Which services does a hospice provide?

A. Home- visiting (patronage) service

B. Home- visiting (patronage) service and inpatient care

C. Inpatient care

D. Day- care attendance

E. Oncology dispensary

9. As death approaches, a person gradually loses interest in:
A. The outside world and everyday details
B. Relatives and close people
C. Themselves
D. All of the above (A, B, C)
E. Modern treatment methods

10. The ethical duty of healthcare workers in palliative medicine includes:
A. Relief of suffering
B. Treating the patient with compassion and respect
C. Understanding the patient's needs
D. Attempting to meet the patient's psychological, social, and spiritual needs
E. Mandatory fulfilment of all wishes of the patient's relatives

11. The aim of palliative care is:
A. Active, comprehensive support for the patient
B. Implementation of measures ensuring adequate pain relief
C. Psychosocial and spiritual support for the patient
D. Searching for modern treatment methods
E. All correct answers: A, B, C

12. Main physical problems of an incurable patient and their family:
A. Pain and other symptoms, wounds, nutrition
B. Control of the primary disease and comorbidities
C. Anxiety, fear, anger
D. Loss, grief, suffering
E. Adjustment of treatment for the primary disease

13. Active general support for an oncology patient at a stage when antitumour therapy is ineffective is:

A. Symptomatic treatment

B. Active supportive therapy

C. Palliative care

D. External radiotherapy

E. Systemic polychemotherapy

14. What should be done for a child during invasive procedures?

A. Analgesia combined with distraction techniques

B. Tell the child to endure because they will feel better afterwards

C. Assure the child that the pain is not severe and will pass quickly

D. Do not allow parents to be present, as this may increase the child's anxiety

E. Procedures should be performed in the same way as for adults

15. The main goal of palliative medical care is:

A. Achieving a quality of life for the dying patient as close as possible to that of a healthy person

B. Psychological support for the patient and their caregivers

C. Meeting the spiritual needs of the patient and their relatives

D. Addressing social, legal, and ethical issues arising from severe illness

E. Philosophical study of oncology problems

16. In addition to the attending physician, who may be involved in caring for patients in palliative- care wards when necessary?

A. Anaesthesiologist

B. Rehabilitation specialist

C. Clergy of various religious denominations

D. Volunteers, including sisters of mercy

E. Correct answers: B, C, D

17. The main, central element of the entire support system for the patient and their family is:

A. The medical aspect

B. The spiritual aspect

C. The psychological aspect

D. The social aspect

E. The rehabilitation aspect

18. Hospice care is:

A. A form of euthanasia

B. A philosophical doctrine

C. A research method in dietetics

D. A form of palliative care

E. Treatment of disease recurrence

19. Specialised palliative- care services in oncology include:

A. A specialised medical group of oncologists

B. Teams combining professionals of different profiles working in hospitals or directly in the community

C. An oncologist

D. A doctor and a social- work specialist

E. A team of social workers, psychologists, and district physicians

20. Relief of suffering in oncology means:

A. Actions aimed at reducing cancer- related pain

B. An ethical duty of healthcare workers

C. Assistance with hygiene procedures

D. Assistance with feeding the patient

E. A form of social support

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
A	A	B	D	C	A	C	B	D	D
11	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
E	A	A	A	A	E	B	D	B	A

DEFINITION AND PRINCIPLES OF PALLIATIVE CARE

According to national and international experts, no fewer than 600,000 people in Ukraine require palliative care each year. These include adults and children in the terminal stages of oncological and cardiovascular diseases, AIDS and tuberculosis, patients with severe traumatic and degenerative lesions of the brain and spinal cord, disorders of the peripheral nervous system and musculoskeletal system, persons with disabilities, and the elderly. In addition, the family members of palliative patients also require professional support. When a person with an incurable illness appears in a family - particularly during the final months and weeks before death - it leads to a decline in the quality of life of the entire household and causes severe psycho- emotional, social, and economic disruption of family functioning. Therefore, alongside specialised medical care, such patients and their relatives require appropriate social, psychological, and spiritual support. Taking into account the needs of relatives and close caregivers, the total number of people requiring palliative support in Ukraine each year is approximately 1.5 million, making this one of the most significant medico- social challenges for the Government and society.

The World Health Organization (WHO) introduced palliative care as a distinct field of medicine in 1982. Initially, palliative care was defined as care for individuals in the final days of life. In 2002, WHO expanded the concept of palliative care.

Today, the most widely used definition is as follows:

Palliative care is a comprehensive approach aimed at ensuring the highest possible quality of life for a patient with an incurable (life- limiting) disease and for their family, through the prevention and relief of suffering by early identification and accurate assessment of emerging problems, and the implementation of appropriate therapeutic measures (for pain syndrome and other disturbances of vital functions), as well as the provision of psychosocial and moral support.

Evolution of the Palliative Care Model is provided in the figure 1.

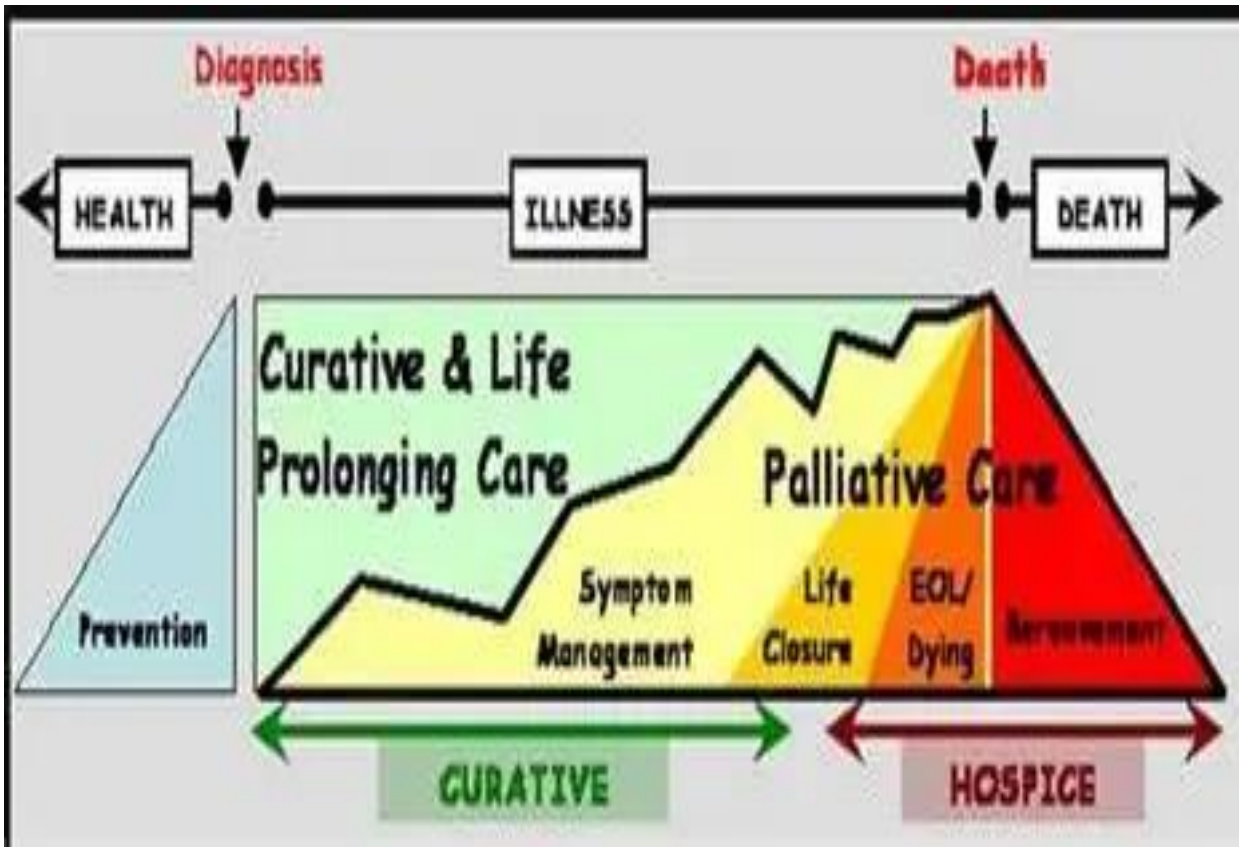


Fig. 1. Evolution of the Palliative Care Model

Image source: Fig. 1. Evolution of the Palliative Care Model - Search Images

The medical component of palliative care consists of monitoring the patient's physical condition, providing symptomatic treatment of pathological manifestations of the disease—including pain—and offering counselling and training to the patient and their relatives in skills required for patient care.

According to modern international approaches and concepts, palliative medicine must be an integral and fully integrated part of healthcare services and social support. The WHO Declaration (1990) and the Barcelona Declaration (1996) call on all countries to incorporate palliative care into their national healthcare systems.

According to existing definitions, palliative medicine is a branch of scientific medicine and healthcare whose primary task is to improve the quality of life and relieve the suffering of patients with various nosological forms of chronic incurable diseases, mainly in the terminal stage of their progression, and in situations where

the possibilities of specialised treatment of the underlying disease are limited or, from the standpoint of modern scientific knowledge, futile [1].

LIST OF MEDICAL INDICATIONS FOR THE PROVISION OF PALLIATIVE CARE

Progressive diseases in their final stages that do not respond to curative treatment and are accompanied by chronic pain syndrome and significant limitations of daily functioning, in the absence of:

- acute diseases
- chronic diseases in an exacerbation phase requiring treatment or monitoring in specialised hospital departments
- acute infectious or psychiatric illnesses that pose a danger to others or staff and require treatment in specialised healthcare facilities
- acute surgical conditions or postoperative states that, due to existing pathology, may require resuscitation measures or monitoring and treatment in intensive- care settings.

Recipients of palliative care include individuals with oncological, cardiovascular, and cerebrovascular diseases, AIDS, tuberculosis, degenerative senile brain disorders, severe genetic pathologies, and other conditions in the final period of life.

Palliative care should begin in parallel with other forms of treatment (e.g., chemotherapy, radiotherapy, surgical or conservative treatment) for patients with incurable chronic diseases. While specific (pathogenetic or aetiotropic) treatment aims at curing the patient, palliative care must ensure the prevention and reduction of suffering caused by the relentless progression of the disease. Palliative care and aetiotropic therapy should be integrated into a single treatment plan. Palliative care must begin before symptoms become uncontrolled.

Decisions regarding the discontinuation of resuscitation measures are made by physicians based on an assessment of the balance between benefit and harm to the patient’s health. The primary condition for any decision is the maximum protection

of the rights and interests of the palliative patient, as well as openness and mutual understanding between the healthcare personnel involved in providing palliative care and the patient's family.

Features of Palliative Medicine

Healthcare professionals often tend to focus primarily on physical problems - disease and treatment - whereas palliative medicine recognises that a human being is more than a physical body. Our intellect, emotional resilience, feelings, and the family and communities to which we belong are all integral parts of who we are. Therefore, the difficulties faced by a patient and their family are not only physical but may also be psychological, social, and spiritual. At times, problems in one area can intensify difficulties in another (for example, pain often worsens when a patient is anxious or depressed). Only by addressing all dimensions of the person can we truly help. In other words, palliative care is a holistic approach.

A holistic approach requires attention to four groups of problems:

- Physical - symptoms (complaints of discomfort), such as pain, cough, fatigue, fever;
- Psychological - anxiety, fears, sadness, anger;
- Social – family needs, issues related to nutrition, employment, housing, and relationships;
- Spiritual – questions about the meaning of life and death, the need for peace, harmony, and reconciliation;
- Palliative medicine is concerned not only with diseases. It addresses all issues that cause the greatest distress to patients. Palliative medicine is about caring for life, not merely providing assistance at the moment of dying.

Many people believe that palliative medicine is care provided only in the last few days of life, but in reality, it is the relief of suffering and the improvement of quality of life from the moment an incurable illness is identified.

Core Practices of Primary Palliative Care is shown in Table 1.

Table 1

Core Practices of Primary Palliative Care [1]

Assess, evaluate, diagnose, treat, and make decisions regarding:	**Identify, assess, provide support, implement appropriate measures, and seek additional assistance when necessary regarding:**
Physical Care Needs	
Pain (all types)	Fatigue
Respiratory Problems (dyspnoea, cough)	Anorexia
Gastrointestinal Problems (constipation, nausea, vomiting, dry mouth, mucositis, diarrhoea)	Anaemia
Delirium	Drowsiness or Lethargy
Wounds, Ulcers, Rashes, and Skin Lesions	Sweating
Insomnia	
Psychological / Emotional / Spiritual Support	
Psychological Distress	Spiritual Needs and Existential Distress
Anxiety	Depression
Family or Caregiver Distress	Bereavement Support for Family Members / Caregivers
Consider and Manage:	
Care Planning and Coordination	
Identify Support and Available Resources; Develop and Implement a Needs-Based Care Plan	
Provide Care in the Last Weeks / Days of Life	
Facilitate Availability and Access to Medications (especially opioids)	
Identify the Psychosocial / Spiritual Needs of Care Providers (including oneself)	
Communication Issues	
Communicate with the patient, family, and caregivers about the diagnosis, prognosis, treatment, symptoms and their management, and issues related to care in the last days / weeks of life	
Identify and establish priorities with the patient and the family / caregivers	
Provide information and guidance to patients and caregivers in accordance with available resources	

SOCIAL AND PSYCHOLOGICAL COMPONENTS OF PALLIATIVE CARE

The social component of palliative care aims to support the most vulnerable groups in society - individuals with incurable illnesses at the end of life. In line with this goal, the tasks of social work in palliative care include empowering the patient, connecting them with supportive resources, ensuring the functioning of a system that provides comprehensive services, and helping ensure that this system meets the patient's needs.

The psychological component of palliative care focuses on alleviating the emotional and psychological states associated with incurable illness; addressing stress, anxiety, and depression experienced by patients, their families, and the healthcare personnel involved in providing palliative care; facilitating discussions and preparation for death; and supporting close relatives during and after bereavement. Palliative care also helps patients maintain the highest possible level of activity until the end of life. Psychological support for the patient's family aims to reduce the emotional burden and stress associated with the terminal illness of a loved one, and to help them cope with grief, including through bereavement counselling when needed.

Most researchers identify five main psychological reactions commonly observed in patients with incurable illnesses:

- Shock
- Denial
- Anger
- Depression
- Acceptance

Experiencing the phase of shock, panic, and despair:

This phase is the most intense and painful not only for the patient but also for relatives and medical staff. In many cases, it is difficult to predict how the situation will unfold; severe stress may trigger a reactive psychosis accompanied by agitation or stupor. In such situations, preventive use of neuroleptics or antidepressants, as well as qualified psychotherapeutic support, may be appropriate.

Typical Trajectory of an Incurable Oncological Disease is provided in the figure 2.

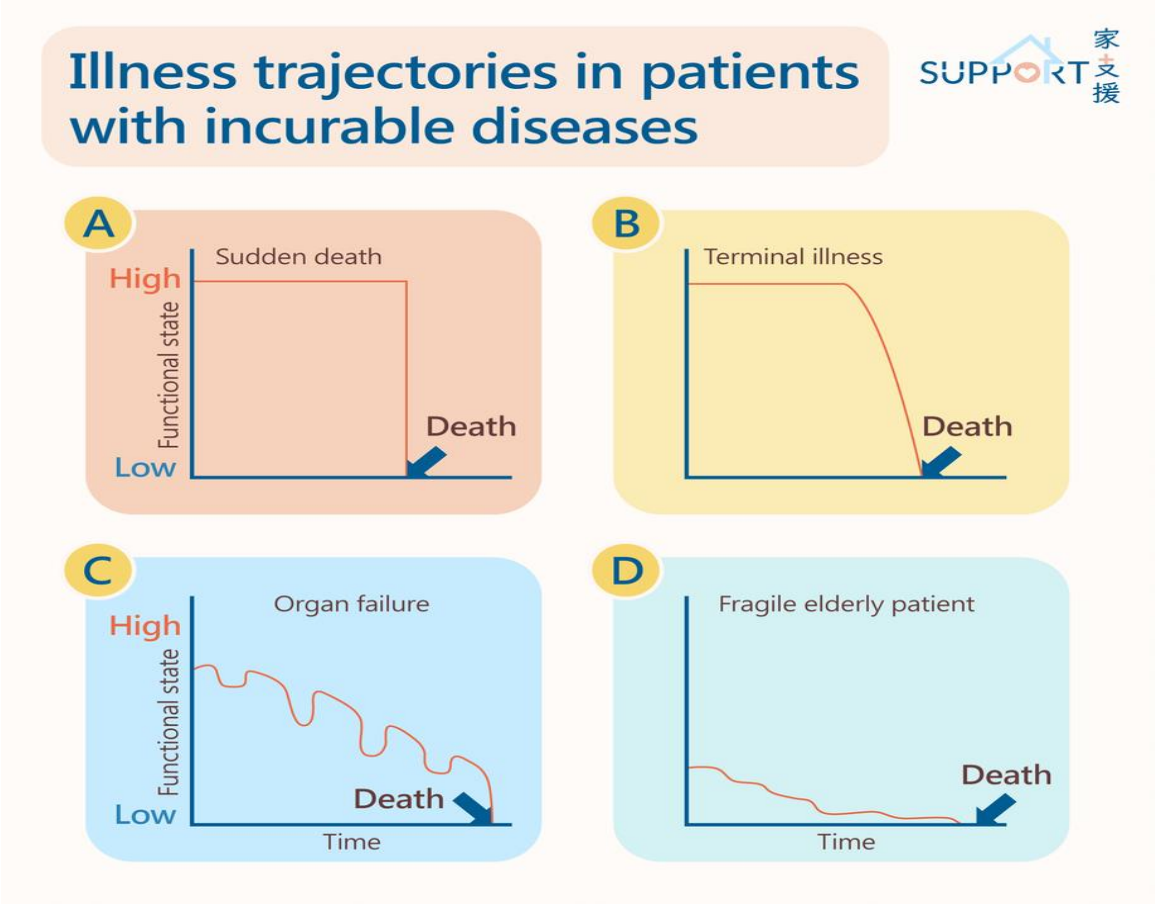


Fig. 2. Typical Trajectory of an Incurable Oncological Disease

Image source: https://support-plus-cms.med.hku.hk/api/assets/hku-support-plus/a0479a11-fa77-454b-a193-d16bcbe04312/illness-trajectories-in-patients-with-incurable-diseases-eng.png?version=0

During the denial phase:

The sense of crisis is pushed into the subconscious, although it remains present in the person's emotional experience. Patients may develop protective thoughts about a possible medical error, hope for miraculous healing, or a favourable outcome. However, psychological symptoms are dominated by despair, preoccupation with death, sad or tragic dreams, and hallucinations.

Trajectory for Older Adults, Frail Individuals, and People with Dementia is shown in the figure 3.

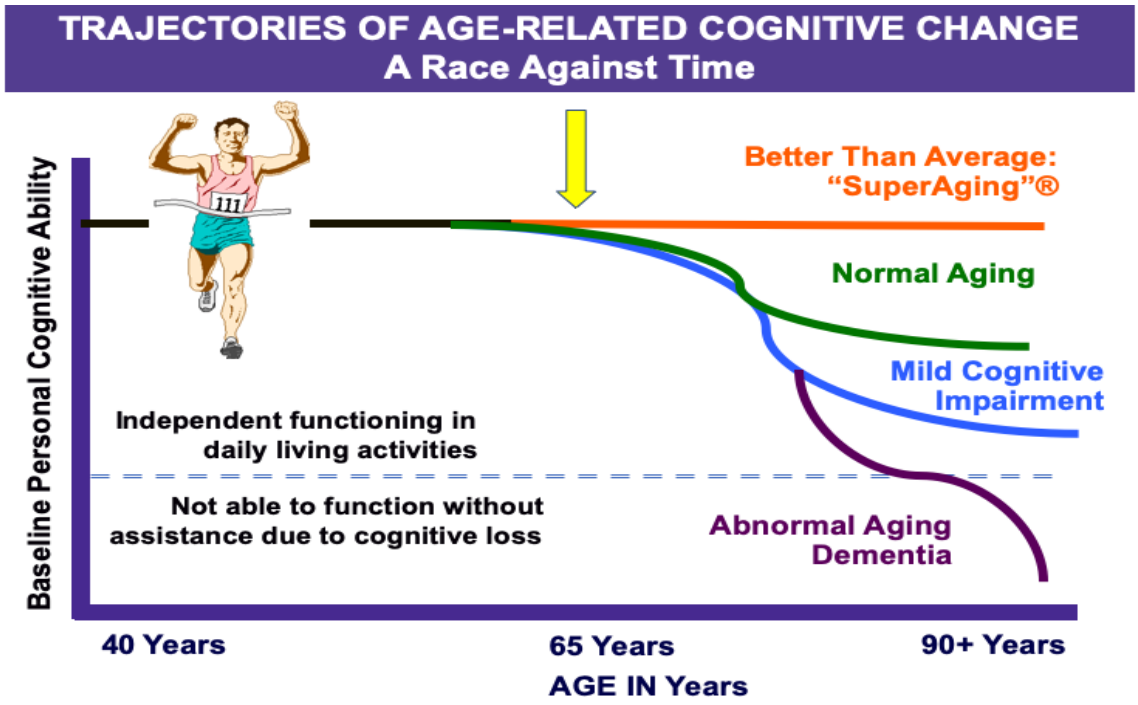


Fig. 3. Trajectory for Older Adults, Frail Individuals, and People with Dementia
Image source: https://www.brain.northwestern.edu/images/aging-trajectory.png

The Anger Phase

The anger phase develops as the patient recognizes the inevitability of the end and begins searching for causes and those to blame. Anger often masks fear and may be dangerous for the patient, who should not be left alone to avoid the risk of suicide. During this phase, anger, indignation, protest, and hatred may be directed toward others, and it becomes a difficult responsibility for healthcare staff to absorb this emotional impact and try to soften it until the emotions begin to subside.

The Depression Phase

This phase is experienced as a deeply internal state of sadness, guilt, regret, and a sense of farewell to the world. Intense emotional expression gives way to withdrawal. At this stage, the most appropriate support is quiet presence and gentle, minimal verbal sympathy. Antidepressant medication may be indicated when necessary.

The Acceptance Phase

The final stage is acceptance, when the patient understands the inevitability of the end and embraces it. During this phase, individuals reassess their life values and the meaning of life, develop an understanding of the completion of their life journey, and often experience calmness and hope for eternal life in another realm.

Trajectory of a Crisis State is shown in the figure 4.

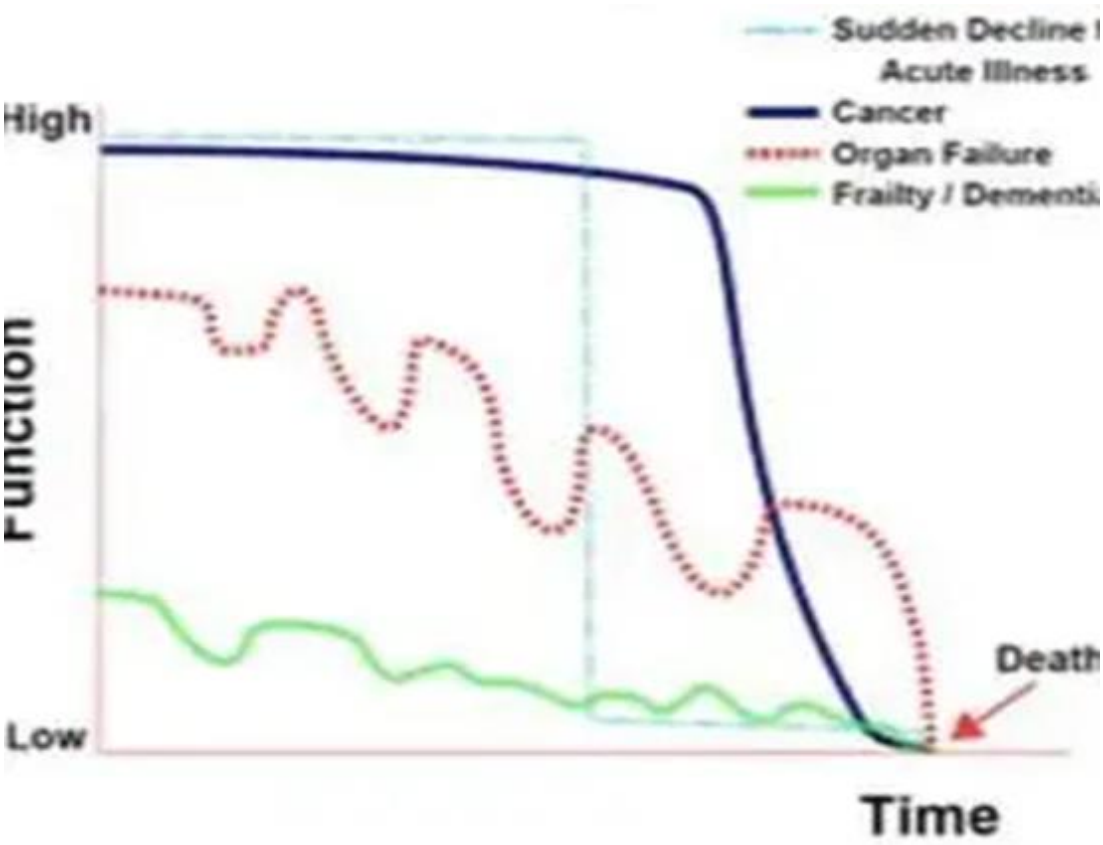


Fig. 4. Trajectory of a Crisis State

Image source: https://th.bing.com/th/id/OIP.zi3ptIalhtju-pK8oNSy-gAAAA?w=174&h=180&c=7&r=0&o=7&dpr=3&pid=1.7&rm=3

It should be noted that the presented scheme is to some extent conditional. In real life, the sequence of the described stages may vary or may not appear at all. Therefore, a mandatory requirement for providing psychological support is qualified psychotherapeutic monitoring of patients.

Spiritual needs

A patient requiring palliative care has an inalienable right to have their spiritual needs met, including through religious practices, in accordance with their beliefs, social, cultural, and spiritual identity or preferences. When a patient's religious affiliation is unclear or uncertain, spiritual support should help them explore and clarify their spiritual, religious, or denominational self- identification, if this is perceived by the patient as a concern or a need.

Ethical issues

Palliative medicine is aimed at addressing the complex problems of patients in a terminal condition. However, it must be remembered that the very concept of the terminal period - its signs and duration - can vary greatly. In palliative practice, the terminal state is understood as the period during which progressive and uncontrolled deterioration of essential bodily functions occurs, inevitably leading to death.

Palliative medicine works alongside other programs and in cooperation with them. It does not replace other forms of care. It can be integrated into existing programs and become part of the care provided to every patient with life- threatening illnesses. Many home- based care programs - such as psychological counselling or practical assistance - are very effective in supporting patients, but they may not be sufficient for managing physical problems such as pain and other severe symptoms. Sometimes home- care staff simply do not know what can be done.

Many inpatient medical programs - such as antiretroviral therapy (ART), chemotherapy, or radiation therapy - are effective for treating disease but do not adequately address psychosocial issues such as anxiety, grief, isolation, and stigma.

Palliative medicine can be integrated into both types of programs so that, together, they can provide comprehensive care.

Symptom Management and Pain Relief + Psychosocial Support = Palliative Care

Depending on the specific circumstances in which patients find themselves, and on the severity of their illness, they may require different types of support.

By the time a person first learns that their illness is incurable, they may still be active, working, doing household tasks, or undergoing treatment such as antiretroviral therapy (ART) or chemotherapy. Palliative care should begin alongside other forms of treatment, providing relief from severe symptoms and side effects, and offering emotional and spiritual support to the patient and their family.

Over time, needs will change - for example, additional symptom management may be required. Some treatments may be discontinued as a holistic approach becomes the priority. Even after the patient's death, palliative care may continue in the form of support for the family, friends, and children during the period of bereavement.



Fig. 5. Hospice Patient Care

Image source: https://www.wesleylife.org/blog/what-is-hospice-care-at-home

Different models of palliative care delivery include:

- Palliative care provided at home
- Day- care palliative services
- Outpatient palliative care service
- Hospital support team
- Inpatient (hospital or hospice) care

SIGNS OF THE TERMINAL STATE

It is clear that the clinical picture and duration of the terminal state vary depending on the underlying pathology. The most general criterion is the ineffectiveness of therapeutic interventions, along with the following signs:

- Total dysfunction of systems essential for sustaining life
- Progressive deterioration of vital systems
- A well- substantiated pessimistic prognosis

- Impairment of the integrative function of the central nervous system
- Indicators for Predicting Life Expectancy.

Patient performance status (energy level and activity) can be used to estimate life expectancy in patients with cancer.

Assessment tools (e.g., Karnofsky Performance Scale, ECOG) are poor predictors of survival once the disease is clearly progressing (Lamont & Christakis, 2007).

Clinical signs and symptoms (dyspnea, dysphagia, weight loss, dry mouth, anorexia, cognitive impairment) are associated with limited survival in cancer patients (Llobera et al., 2000; Vigano et al., 2000).

Biological markers (e.g., elevated platelet count, decreased serum albumin) may also indicate limited life expectancy (Lamont & Christakis, 2007).

Clinician predictions: although clinicians tend to overestimate survival, it is useful to ask:

"Would I be surprised if this patient died within the next six months?"

This question helps determine when further discussions, treatment- goal reassessment, and appropriate palliative services are needed to ensure comfort and enhanced psychological, social, and spiritual support (Lynn et al., 2000).

Decision- Making and the Venetian Declaration

When deciding to transition a patient to palliative treatment, the physician should be guided by the principles of the Venetian Declaration:

1. In the course of treatment, the physician is obliged, whenever possible, to relieve the patient's suffering, always acting in the patient's best interests. No exceptions to this principle are allowed, even in cases of incurable illness.

3.1. A physician must not prolong the suffering of a dying patient by continuing treatment that can only delay the inevitable end, if the patient (or relatives, when the patient is unconscious) requests its discontinuation. Refusal of treatment does not release the physician from the duty to assist the dying person by prescribing medications that relieve suffering.

3.2. A physician must refrain from using non- standard therapeutic methods that, in their opinion, will not bring real benefit to the patient.

Ethical Considerations

Recognizing the inevitability of death, one must remember that life is unique and should be supported as long as doing so aligns with the patient's interests and wishes. At the same time, the physician has neither a moral nor legal right to prolong suffering. Every effort must be made to relieve the patient from physical and emotional distress and from a prolonged dying process.

If the patient's physical and emotional suffering is unbearable and cannot be alleviated, the possibility of inducing a medically supervised sedative state should be discussed - without depriving the patient of life.

No matter how much we strive to prolong life, there comes a stage when death is inevitable. Resuscitation is justified only when the patient can be returned to conscious life without suffering. In all other cases, however painful it may be, death becomes a release from suffering. A physician's duty is not to preserve life at any cost; at a certain point, the physician must allow the patient to die peacefully.

The fading of hope, indifference, apathy, and refusal of food

These are signs that the patient has stopped resisting and has accepted the inevitability of death. Intensive therapy and resuscitation in such cases are unlikely to be justified.

Because many medical decisions are based on more or less substantiated assumptions, all important issues should be discussed collectively, involving the medical staff, the patient, and the patient's relatives, in order to avoid mistakes.

THE GOAL OF PALLIATIVE CARE

Thus, palliative care:

- Provides relief from pain and other symptoms or functional disturbances that cause suffering
- Affirms life and regards death as a natural process
- Does not aim to hasten or postpone death

- Integrates social, psychological, and spiritual aspects of patient care
- Offers a support system that helps the patient live as actively as possible until death
- Offers a support system that helps the family cope during the patient's illness and through the period of bereavement
- Uses a comprehensive interdisciplinary (team- based) approach focused on the needs of the patient and their family
- Improves quality of life and positively influences the course of illness

Is applicable at any stage of disease and can be provided alongside life- prolonging therapies such as chemotherapy or radiotherapy, and includes investigations needed to better understand disease dynamics, control, and prevention of clinical complications

KEY PRINCIPLES OF PALLIATIVE THERAPY

1. Identifying the main causes of deterioration in the patient's condition (pain syndrome, nutritional disorders, metabolic disturbances, neuropsychological disorders, compression of vital organs, etc.)
2. Determining the leading factor that caused the development of a particular pathological syndrome - manifestations of the tumour process itself, nonspecific complications, paraneoplastic signs, consequences of anticancer treatment, comorbidities, neuropsychological reactions
3. Timely diagnosis of acute pathology requiring urgent, including surgical, intervention; hospitalization when necessary for intensive therapy
4. Organizing a system of care, diet, and regimen, and creating a favorable psychological environment for the patient
5. Recognizing the type of accompanying psycho- emotional disturbances and correcting them
6. Using general health- promoting measures
7. Prescribing medications as indicated, following the principle of escalation from mild to strong agents, with timely rotation to prevent tolerance

8. Using psychotropic medications that soften or reduce the patient's perception and awareness of the severity of their illness

9. Consistently adhering to the principles of oncological deontology, particularly maintaining the patient's hope for a favourable outcome.

PALLIATIVE CARE FOR CHILDREN

Palliative care for children is a complex of medical, psychological, social and spiritual measures aimed at improving the quality of life of a child with an incurable or life-threatening illness, as well as supporting their family. According to the World Health Organization, such care should begin from the moment of diagnosis and be provided in parallel with the main treatment.

The WHO has also provided a definition of palliative care for children.

Paediatric palliative care is a distinct field, although closely related to palliative care for adults. The principles applied in cases of paediatric incurable illnesses include:

- Palliative care for children is the active and comprehensive care of the child's body, mind, and spirit, and also includes support for the family.
- Palliative care for children begins at the moment the illness is diagnosed and continues regardless of whether the child is receiving disease- directed treatment.
- The person providing palliative care to a child must monitor and strive to eliminate or reduce the child's physical and psychological suffering and ensure appropriate social conditions.
- Effective paediatric palliative care requires a comprehensive multidisciplinary approach that involves the family and makes community resources accessible; it can be successfully implemented even when resources are limited.
- Palliative care for children can be provided even with limited specialized medical resources - in general healthcare facilities or even in the child's home.

Basic principles:

• focus on the needs of the child and family;

• respect for the dignity and rights of the child;

• interdisciplinary approach;

• continuity of care;

• accessibility regardless of place of residence.

Target group

Children in need of palliative care include patients with:

• oncological diseases;

• severe genetic and orphan diseases;

• neurological disorders (for example, severe cerebral palsy);

• congenital malformations;

• progressive metabolic diseases;

• conditions after severe injuries.

Organization of Care

Palliative care for children in Ukraine is provided in the following forms:
• inpatient care (hospital departments, hospices);
• outpatient care;
• mobile outreach teams;
• home-based care.

Specialized institutions play an important role. Cooperation with community-based and international organizations is also actively developing.

Medical Component

A key element is the management of pain and other symptoms:
• use of analgesics (including opioids); • treatment of dyspnea, nausea, and seizures;
• nutritional support;
• palliative sedation (when indicated).

Special attention is given to the individualized selection of therapy and the safe use of medications in children.

Psychosocial support

Palliative care involves:

• psychological support for the child;
• counseling for parents;
• assistance in making difficult decisions;
• support during the period of loss (grief management).

Psychologists, social workers, teachers, and spiritual mentors are involved in the work.

Palliative care for children is an important component of the healthcare system, aimed at ensuring a dignified life for a child regardless of the severity of their illness. Further development of this area requires systemic changes, intersectoral cooperation and raising public awareness.

CONCEPT OF A HOSPICE

Palliative treatment must be available to the patient around the clock and provided in a volume acceptable to the patient, in accordance with approved standards and clinical protocols. Palliative care may be delivered - based on the patient's needs and consent - at home, in outpatient clinics (as a consultative service), or in inpatient healthcare facilities of any form of ownership, using various organizational models of medical care, including day- care units and specialized inpatient facilities (hospices or palliative care wards).

For example, if a patient wishes to receive palliative care at home, healthcare workers can train family members, close friends, or neighbours who provide care to administer prescribed medications correctly and offer other types of medical and psychological support. They must also be able to contact healthcare professionals for consultation when needed. Therefore, the WHO recognizes that every country must establish appropriate services to meet the medical and social needs of palliative patients.

A facility where incurable patients can receive professional, specialized, comprehensive, and multidisciplinary palliative care is called a hospice. A hospice

is a state medical institution for incurable patients, aimed at providing palliative (symptomatic) treatment, selecting appropriate pain- relief therapy, and offering medical- social care, nursing, and psychological support for relatives during the illness and after the loss of a loved one.

Hospice services constitute a system of care that provides palliative support to patients with limited life expectancy who require comprehensive biomedical, psychological, and spiritual assistance as they enter the final stage of illness or decline (National Quality Forum, 2006). In addition, a hospice:

- Supports the patient during the dying process, and the family both during dying and throughout bereavement
- Provides comprehensive medical services and support through various means, based on the understanding that dying is part of the normal life cycle
- Offers care at home, in residential care facilities, hospitals, nursing homes, and other institutions (e.g., prisons).

Thus, a hospice is a facility for people with incurable diseases, often in terminal stages, who require continuous assistance and care. At the same time, a hospice is not a typical hospital, because its focus is not on expensive equipment but on a special atmosphere and staff capable of understanding the patient, sharing their joys and sorrows, offering compassion, comfort, and reassurance. This is ensured by round- the- clock service from a team of professionals (physicians, nurses, dietitians, psychologists, clergy, insurance specialists) and trained volunteers.

Key components of hospice care include nutrition (including tube feeding), symptomatic therapy (including pain management), hygiene care, parenteral nutrition, antibiotic therapy, chemotherapy, and palliative radiotherapy.

The primary mission of a hospice is to create normal living conditions for a person in the terminal stage of life. The main goal is not to prolong life at any cost, but to ensure its quality. It is essential to create a special psychotherapeutic environment for the dying person, ensuring maximum comfort and complete relief from pain.

A hospice must prevent and alleviate fear of pain, death, loneliness, and abandonment, while providing professional medical care and compassion for the needs and concerns of the patient's loved ones.

FUNCTIONS OF A HOSPICE

Key issues addressed in a hospice

- Pain relief, which is the foundation for the successful implementation of all other hospice interventions. This includes creating maximum physical and psychological comfort and providing psychotherapeutic support. Staff ensure care for stomas, monitor physiological elimination, prevent, and treat pressure ulcers, and more.
- Support for the patient's family during the terminal period and after the patient's death. The hospice may assist with certain funeral- related matters. When needed, family members receive psychotherapeutic services. Many hospices also operate mobile teams consisting of physicians, nurses, psychologists, and volunteers.

The organizational- methodological department of a hospice systematizes information about its work, develops a scientific and informational base, and designs social programs aimed at understanding patient and family attitudes toward hospice care and assessing the societal value of such institutions.

Pain Relief as a Priority

Pain relief is the top priority in hospice care. Pain is the most common and severe symptom of the terminal period. Between 50–60% of terminally ill patients experience significant pain; among cancer patients, this number reaches up to 80%.

Effective pain control requires the use of the WHO three- step analgesic ladder, which considers pain intensity, pharmacodynamics of analgesics, adjuvants, and co- analgesics. Clinical experience shows that with an appropriately selected treatment plan - combined with addressing psychological and social issues of both the patient and the family - it is possible to achieve satisfactory pain control and significantly reduce the need for narcotic medications.

Creating Physical and Psychological Comfort

Creating physical and psychological comfort is the essence of palliative care and is only possible when pain is adequately managed.

Care for oncology patients in the IV clinical group includes:

- Monitoring physiological elimination (natural or through stomas)
- Care for ulcers and wounds
- Prevention and treatment of pressure ulcers

Psychological support is provided by medical staff, trained psychotherapists, and spiritual caregivers (priests, nuns).

A hospice also provides psychological support to the patient's family and prepares them for the natural outcome of the illness.

Staff Qualifications and Philosophy of Care

Effective hospice care requires not only professional qualifications but also specific personal qualities of the staff. Hospice workers must rethink many traditional principles of medical practice. The goal is not to prolong life at any cost, but to make the patient's final days comfortable and meaningful. Standard medical care for typical patients is often unsuitable for those who are dying.

Hospice programs offer both inpatient and outpatient care, as well as emotional preparation for relatives, caregivers, and staff involved in caring for a terminally ill patient.

Core Elements of Hospice Models

- Although hospice models differ structurally, they share several key elements:
- Care is holistic, not fragmented or purely biomedical
- Support systems are designed for both the patient and the family
- Death is viewed as a natural part of the life cycle, not something to be denied
- Care is interdisciplinary, addressing physical, psychological, spiritual, and social needs
- Services include education and support for the patient and family

- Care extends to all individuals with life- threatening illnesses and their relatives
- Bereavement support is provided to ease the emotional burden of loss

The ultimate goal is to improve the quality of life of the patient and their family.

ORGANISATION OF THE MULTIDISCIPLINARY APPROACH

The main mechanism for providing palliative care at home is the creation of a multidisciplinary palliative care team. This model makes it possible to offer the patient comprehensive, holistic support rather than purely medical or purely social assistance.

The minimum composition of a multidisciplinary palliative care team includes:

- healthcare and social- care professionals
- a psychologist
- a social worker
- volunteers.

Family members may also be considered part of the team if they have acquired the necessary skills to care for a palliative patient. The composition of the team is not fixed; it depends on the specific situation, the patient's needs, and the resources available.

Palliative care for children - most often provided at home - requires the inclusion of a paediatrician in the team.

Within a multidisciplinary palliative care team, the medical component is based primarily on pain relief. This is followed by nursing care, which creates the conditions for physical comfort (as far as possible). The most complex issues are psychological, as they concern both the inner world of the patient and their relationships with the surrounding environment, interests, and daily life.

For palliative patients, in addition to social and domestic support, access to legal assistance is also essential.

Support for the patient's family should begin from the moment a chronic illness is diagnosed, during the initial assessment of the situation, and continue throughout

the entire period of palliative care. An important stage is support during the period of bereavement.

General provisions on the multidisciplinary approach to palliative care are presented in Appendix 1.

PAIN SYNDROME IN INCURABLE PATIENTS

Mechanism of Pain Syndrome in Incurable Patients

The pharmacological component of palliative and hospice medicine represents, for the most part, the principal element in the system of measures aimed at combating (controlling) the symptoms of the underlying disease and/or - when necessary - the consequences of medical interventions (particularly aggressive chemotherapy) that cause the greatest suffering to the patient. Among these, pain syndrome is the most prominent, followed by psycho- emotional disorders (especially in oncological conditions) and other adverse clinical manifestations associated with damage to the skin and mucous membranes (including the oral cavity, intestines, etc.), bone tissue (osteoporosis), and dysfunction of vital organs and systems such as the cardiovascular system, liver, kidneys, and lungs, which are commonly observed in the final months or days of life.

The most important place within the pharmacological measures of palliative medicine is occupied by the management of chronic pain syndrome.

Pain is a subjective sensation and experience that arises as the body’s response to harmful or destructive stimuli. From a physiological perspective, pain is a biologically significant protective mechanism that signals life- threatening danger and contributes to the preservation of the organism’s integrity.

However, extremely intense pain and prolonged painful stimulation—such as that caused by the growth of a malignant tumour or other factors—together with the associated severe pain experience, lead to persistent pathological reactions in both the peripheral and central nervous systems. Chronic pain poses a danger to the body, causing neurophysiological changes and disturbances in the organism’s homeostasis. With prolonged severe pain, chronic pain syndrome develops, which

is characteristic of many chronic diseases and almost all common types of malignant tumours in stages III–IV.

Types of Chronic Pain

Chronic pain, including that associated with progressive cancer (clinical stages III and IV), may be constant or intermittent, depending on the location of the pathological focus, its extent, or previous treatment.

By intensity, pain is classified as mild, moderate, severe, or very severe (also referred to as “unbearable” pain). Assessment of pain intensity, based on the patient’s subjective sensations, is carried out both before treatment and during treatment to determine the effectiveness of analgesia.

For this purpose, palliative medicine most commonly recommends the five- point verbal rating scale for chronic pain intensity:

0 — no pain

1 — mild pain

2 — moderate pain

3 — severe pain

4 — the most severe pain

A visual analogue scale (VAS) (Fig. 1) may also be used, representing a 10- cm line corresponding to pain intensity from 0 to 100%, on which the patient marks the strength of their pain.

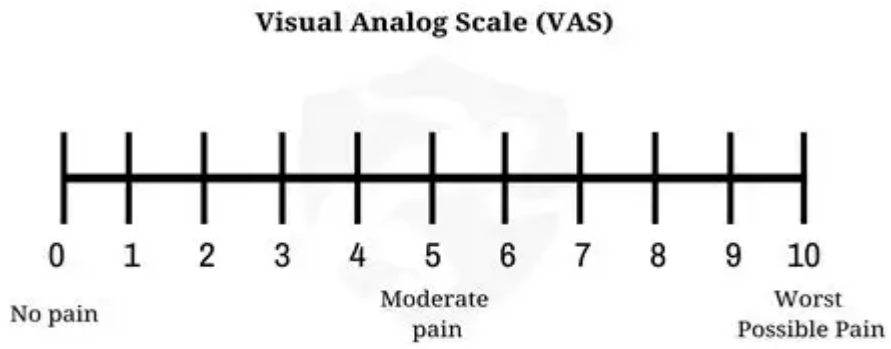


Fig. 6. Visual Analogue Scale (VAS) for Assessing Pain Intensity

Image source: https://www.bing.com/images/search?view=detailV2&ccid

Such scales are necessary for the quantitative assessment of changes in the intensity of chronic pain syndrome during treatment and for selecting the appropriate analgesics and their dosing regimen.

Considering the recommendations of the International Association for the Study of Pain (IASP), several pathogenetically justified types of pain are distinguished according to their source. Each type of pain is caused by varying degrees of damage to soft tissues, bones, and internal organs, either by the malignant tumour itself or by its metastases (see Appendix 6).

The following types of pain are recognised:

• Nociceptive pain:

a) Somatic pain – irritation of nociceptors:

• bone involvement

• soft- tissue involvement

• muscle spasm

b) Visceral pain:

– carcinomatosis of serous membranes

– hydrothorax

– ascites

– overstretching of the walls of hollow organs and the capsules of parenchymal organs

• Neuropathic pain – overstimulation or damage to neural structures

• Causalgia – pain intensified by sympathetic nerves; a mixed disturbance of peripheral innervation in primary nociceptive and post- ganglionic sympathetic fibres caused by tumour growth

Pain Assessment in Newborns

Parameter	0 points	1 point	2 points
Face	Neutral facial expression	Rarely grimace or knitted eyebrows. Unsociability. No interest is expressed	Chin shaking frequently or constantly, jaw clenching
Legs	Normal position, relaxed	Inability to find a normal position, constantly moving legs, legs tense	Kicking or raising legs
Activity	Calm normal lying position, free movements	Writhing, shifting back and forth, tense	Bending, rigidity, twitching
Cry	Absence of cry (during sleep or wakefulness)	Groaning or whimpering, sometimes complains	Cry for a long time, screams or sobs, often complains
Consolability	Satisfied, calm	Calms down from touching, hugging, talking. Can be distracted	Difficult to calm down

Fig. 7. DAN Scale

Image source:

https://www.researchgate.net/publication/353134034/figure/download/tbl1/AS:1066236238635008@1631221937945/Pain-assessment-scale-for-newborns-infants-children-under-3-years-of-age-and-children.png

Nociceptive pain may be described as deep, throbbing, dull, or like the painful sensations that occur after a blow. Neuropathic pain arises as a result of damage to the myelin sheath of peripheral nerve axons. It is typically a manifestation of peripheral symmetrical polyneuropathy (PSP) and is characterised by reduced sensitivity, numbness, tinnitus, “tingling”, and painful sensations, predominantly in the lower limbs and feet.

Neurophysiological reactions and pathobiochemical changes in chronic pain, in turn, lead to the development of pathopsychological alterations in the brain, which form a persistent chronic pain syndrome. In the terminal period of life, chronic pain syndrome differs significantly from acute pain due to the persistence and intensity of the pain experienced by the patient. These manifestations include marked psychological changes, the development of reduced responsiveness to analgesic medicines and other therapeutic interventions, and the possible emergence of vital depression.

CLASSIFICATION OF PAIN AND ANALGESIA IN CHRONIC PAIN SYNDROME

According to WHO recommendations, there are three main levels of analgesia for chronic pain syndrome in oncology patients:

• Level 1 – Mild pain

Non- opioid analgesics and non- steroidal anti- inflammatory drugs (NSAIDs) with analgesic properties are prescribed (Paracetamol, Metamizole sodium, Diclofenac, Indomethacin, Ketorolac, Ibuprofen, Meloxicam, Nimesulide, salicylates; see Appendix 3).

If necessary, additional (adjuvant) medicines may be used to control other symptoms, including sedatives (hypnotics, anxiolytics, antidepressants), antiemetics, glucocorticoids, and diphosphonates.

• Level 2 – Moderate pain

If non- opioid analgesics alone are insufficient, weak opioid analgesics from the codeine group are added to Level 1 medicines - Codeine, Hydrocodone - along with the adjuvant medicines listed above.

• Level 3 – Severe or unbearable pain.

If Levels 1 and 2 are ineffective, strong opioid analgesics are prescribed (Morphine, Tramadol, Hydromorphone, Fentanyl, Buprenorphine, Butorphanol, Trimeperidine, Nalbuphine, and long- acting opioids, including transdermal formulations).

Non- opioid analgesics and necessary adjuvant (symptomatic) medicines are not discontinued.

Opioid dosing is selected according to the ascending principle (from lower to higher doses; see Appendix 4) until the required pharmacotherapeutic effect is achieved.

FLACC Score			
CATEGORY	0 POINTS	1 POINT	2 POINTS
Face	Disinterested	Occasional grimace, withdrawn	Frequent frown, clenched jaw
Legs	No position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Normal position	Squirming, tense	Arched, rigid, or jerking
Cry	No crying	Moans or whimpers	Constant crying, screams or sobs
Consolability	Content, relaxed	Distractible	Inconsolable
SCORES ADD UP IN RANGE FROM 0–10			

Fig. 8. FLACC Scale

Image source: https://s3.amazonaws.com/HMP/hmp_ln/imported/2021-05/2106%20Pedi%20pain%20FLACC%20score%20EMS.jpg

For predicting the need for long- term opioid analgesia for chronic non- cancer pain, the DIRE score is used (see Appendix 2).

The scheme for the use of opioid analgesics together with peripherally acting analgesics and adjuvant medicines at the different steps of the WHO/IAHPC analgesic ladder is presented in Table 2 and in Appendix 5.

Table 2

Classification of pain and medicines used for analgesia in chronic pain syndrome [3]

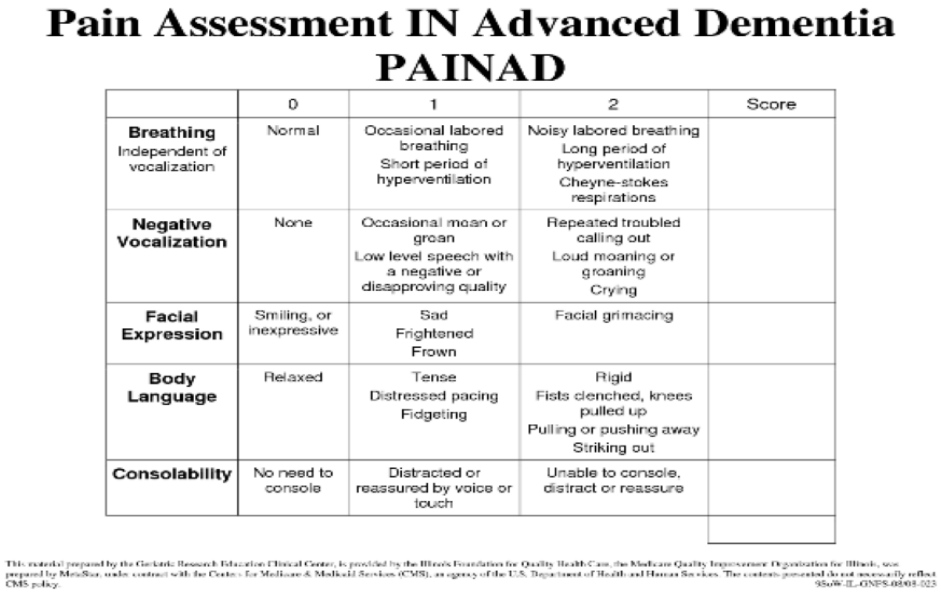
WHO Analgesic Ladder	Analgesics of Choice
1st step *mild / slight pain*	**Acetylsalicylic acid, Paracetamol and other NSAIDs + adjuvant medicines**

WHO Analgesic Ladder	Analgesics of Choice
2nd step *moderate pain*	**Weak opioids** (Codeine, Tramadol) **+ Paracetamol and other NSAIDs + adjuvant medicines**
3rd step *severe / intense pain*	**Strong opioids** (Morphine, Fentanyl, Hydromorphone, Methadone, Buprenorphine, Trimeperidine, Butorphanol, Nalbuphine) **+ adjuvant medicines**

To eliminate or alleviate other symptoms that cause the greatest suffering to patients and are characteristic of the terminal stage of oncological and other chronic incurable diseases, palliative medicine employs medicinal products aimed at correcting cachexia and general disturbances of protein metabolism, dyspeptic disorders, haemorrhagic syndrome, haematological abnormalities and immunocorrection, infectious complications, ulcerative lesions of the skin and mucous membranes, urinary disorders, manifestations of osteoporosis and hypercalcaemia, biochemical dysfunctions (including impaired hepatic detoxification), as well as symptomatic treatment of oedema, lymphoedema, effusions into serous cavities, and compressive cerebral or mediastinal complications resulting from tumour growth.

Adjuvant Medicines in Palliative and Hospice Care

To eliminate or reduce the manifestations of various clinical symptoms - other than chronic pain - that cause significant suffering to patients and are typical of the terminal stage of oncological and other chronic incurable diseases, palliative medicine prescribes adjuvant (supportive) medicinal products.



Pain Assessment IN Advanced Dementia
PAINAD

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing Short period of hyperventilation	Noisy labored breathing Long period of hyperventilation Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan Low level speech with a negative or disapproving quality	Repeated troubled calling out Loud moaning or groaning Crying	
Facial Expression	Smiling, or inexpressive	Sad Frightened Frown	Facial grimacing	
Body Language	Relaxed	Tense Distressed pacing Fidgeting	Rigid Fists clenched, knees pulled up Pulling or pushing away Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	

This material prepared by the Geriatric Research Education Clinical Center, is provided by the Illinois Foundation for Quality Health Care, the Medicare Quality Improvement Organization for Illinois, was prepared by MetaStar, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 95a06-IL-GNPS-0808-023

Fig. 9. Pain Assessment in the Final Stages of Dementia
Image source: https://alzheimersinyourhome.b-cdn.net/wp-content/uploads/2024/01/painad600.png

Adjuvant medicines generally include psychotropic agents, anticonvulsants, antiemetics, and medicines used to manage disorders of the cardiovascular system, kidneys, and biochemical functions - particularly the detoxification function of the liver. They are also used for haematological abnormalities and immunocorrection, treatment of infectious complications, dyspeptic disorders, ulcerative lesions of the skin and mucous membranes, haemorrhagic syndrome, reduction of osteoporosis and hypercalcaemia, correction of cachexia and general disturbances of protein metabolism, symptomatic treatment of oedema, lymphoedema, effusions into serous cavities, and compressive cerebral or mediastinal complications resulting from tumour growth.

In addition, some adjuvant neuro- and psychotropic medicines can enhance the effectiveness of analgesics, broaden their therapeutic range, or possess independent analgesic properties in cases of nociceptive or neuropathic pain. Such medicines include, in particular, anticonvulsants, tricyclic antidepressants, benzodiazepines, antihistamines, and α_2 - adrenoceptor agonists.

The use of adjuvant medicines is of particular importance in cases of unbearable neuropathic pain that cannot be controlled by classical analgesic medicines. In this clinical situation, the following groups of medicines are recommended:

- Opioid analgesics
- Glucocorticosteroids
- Adjuvant medicines, including medicines from the classes of antidepressants, anticonvulsants, anxiolytics, neuroleptics, hypnotics and sedatives, antihistamines, local anaesthetics, and central alpha- adrenoceptor agonists.
-

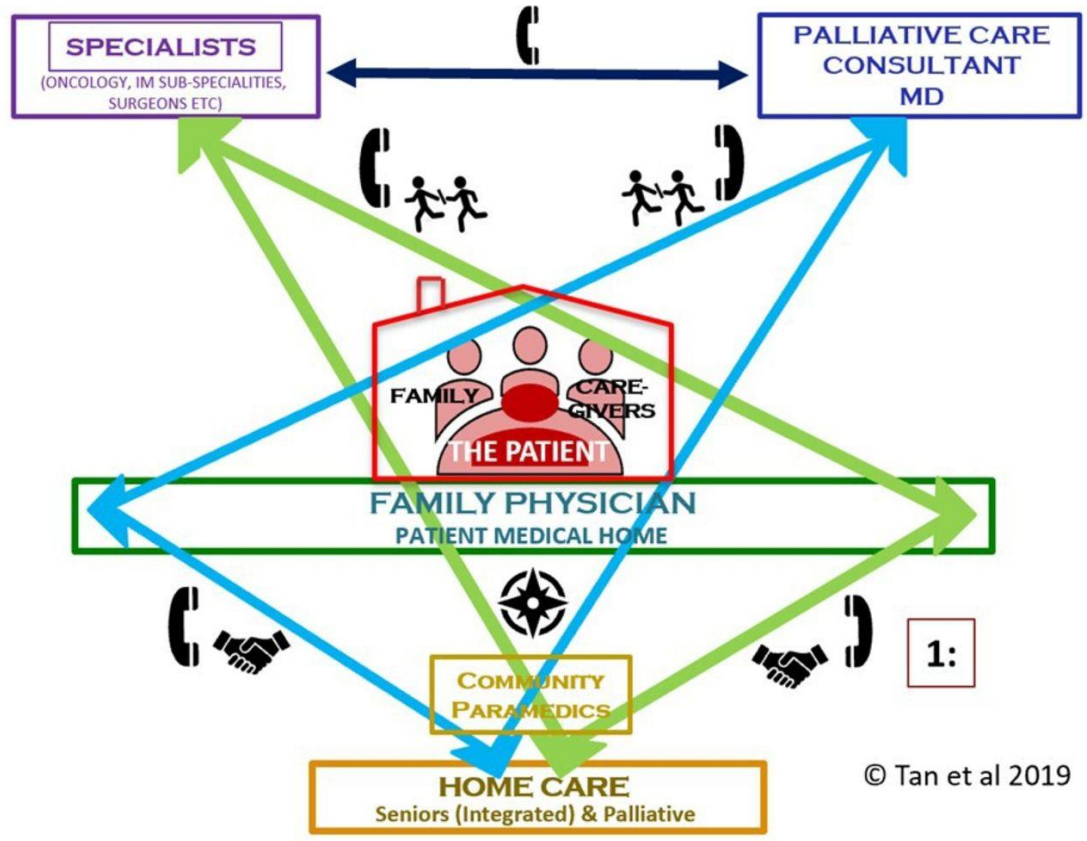


Fig. 10. Patient Monitoring Plan for Individuals Requiring Palliative Care

Image source:

https://bmjopen.bmj.com/content/bmjopen/11/12/e048667/F4.large.jpg

Severe and unbearable pain in oncology patients is often caused by bone metastases, which are accompanied by osteoclastic bone resorption, hypercalcaemia,

and pathological fractures. To reduce pathological processes in bone tissue and thereby alleviate pain syndrome, palliative care employs bisphosphonates and calcitonin, which act as inhibitors of osteoclastic activity.

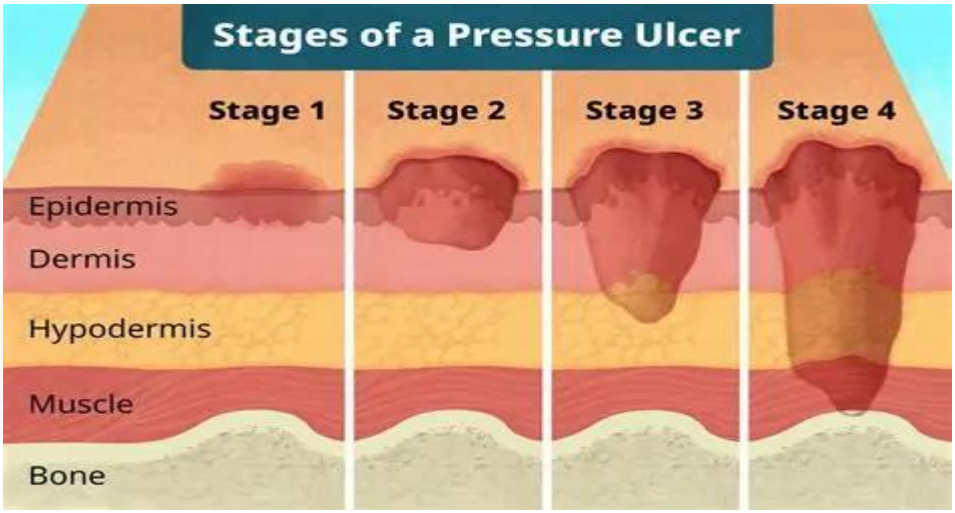


Fig. 11. Stages of Pressure Ulcer Severity

Image source:

https://www.verywellhealth.com/thmb/ppzAtl4VXq8mErwZlXbfleCIaLc=/1500x0/filters:no_upscale():max_bytes(150000):strip_icc()/VWH-MiraNorian-StagesofaPressureUlcer-Standard-27c3b9a3c4d94bf2a7c6fd1e90f4e81a.jpg

The analgesic effect of bisphosphonates is due to the reduction of osteoclastic activity and hypercalcaemia, and it has been clinically confirmed in cases of bone pain resulting from breast cancer and prostate cancer metastases.

PHYSICAL METHODS OF TREATING CHRONIC PAIN

Given the complexity and diversity of the pathogenetic mechanisms underlying chronic pain, its treatment cannot be limited to pharmacological methods alone. In many cases, significant relief may be achieved through the use of physical modalities, such as heat, cold, light, water, mechanical stimulation, dynamic loading, and electrical current.

Physical methods often help break the vicious cycle of “pain – muscle tension – impaired circulation – pain”.

Heat Therapy

Heat therapy is particularly effective in treating muscle spasms, myofascial pain, and general musculoskeletal discomfort associated with immobility and weakness. Heating reduces pain both as a competing sensory stimulus and through direct effects on tissues.

The sensation of warmth reduces nociceptive transmission in the dorsal horns of the spinal cord and may exert an inhibitory effect at the level of the brainstem.

Local effects of heat include:

- muscle relaxation
- increased blood flow
- improved tissue elasticity

Superficial heat is applied using water or electric heating pads or special lamps.

Deep tissue heating is achieved through ultrasound, short- wave diathermy, or microwaves.

Heat therapy is contraindicated:

- over areas adjacent to metal or synthetic prostheses, or regions containing bone cement
- in areas with reduced sensitivity, paralysed body parts, or ischaemic tissues
- over infected areas
- directly over a tumour site

Cryotherapy

Cryotherapy reduces local inflammatory responses and decreases the release of inflammatory mediators through the application of cold. It is indicated for spastic muscle pain.

Methods include ice packs, cold water, or spraying with cooling agents such as chloroethyl.

Cryotherapy is contraindicated in areas with impaired sensation or insufficient blood supply.

Mechanical Therapies (Touch, Massage)

Mechanical methods can relieve pain caused by muscle spasm, myofascial syndromes, or general musculoskeletal discomfort associated with immobility and weakness.

A conscious, gentle touch has a calming and warming effect and carries no side effects.

Vibration therapy may be used to relieve muscle pain, tension, post- nerve- injury pain, and pain after amputations.

Massage:

- promotes endorphin release
- induces general and muscular relaxation
- is an ideal means of expressing care for the patient

Massage should prepare the patient for physical activity rather than replace it.

Physical Exercise

Both active and passive exercises can improve pain control and reduce general musculoskeletal discomfort associated with immobility and weakness.

Physical activity stimulates endorphin production, improves mood, and enhances emotional well- being.

With appropriately dosed exercise, the patient's overall physical condition may improve, helping to mitigate negative manifestations of disease progression.

Manual Therapy

Manual therapy is used for non- oncological back pain.

It is contraindicated in oncology patients when metastatic involvement of the spine is present or suspected.

Orthopaedic Devices and Supports

Prostheses, splints, and other supportive devices can relieve or prevent pain by stabilising or immobilising affected areas.

Walking aids - crutches, canes, and walkers - play an important role in preventing movement- related pain.

Immobilisation

The use of a wheelchair or bed rest may be necessary for patients experiencing severe pain despite optimal analgesic therapy and the use of the physical support methods described above.

ROLE AND PLACE OF INSTRUMENTAL, DIAGNOSTIC AND THERAPEUTIC METHODS IN PALLIATIVE CARE

Virtually all high- technology diagnostic and therapeutic methods known in medicine are widely and successfully used in palliative medical care (PMC) and form the basis of approaches aimed at improving the quality of life of patients with progressive chronic diseases.

Instrumental diagnostic methods used in PMC include ultrasound, radiological examinations, esophagogastroduodenoscopy (OGD), bronchoscopy, colonoscopy, radionuclide diagnostics, and PET- CT.

Instrumental therapeutic interventions include cavity drainage, stenting of hollow organs, stoma formation, radiotherapy, respiratory support, photodynamic therapy, and interventional methods for chronic pain management, among others.

In view of the above, an important task today is the scientifically grounded determination of the needs of patients with progressive chronic diseases for specialised PMC involving instrumental diagnostic and therapeutic interventions, including high- technology methods provided by qualified specialists in a specialised inpatient setting.

According to available data, the following methods have become the most widely used in palliative medicine in recent years.

Minimally Invasive Surgical (Endovideoscopic, Endoscopic) Technologies

These include:

- percutaneous endoscopic gastrostomy
- endoscopic stenting of the oesophagus and gastric cardia, duodenum, and colon
- endoscopic stenting of the biliary ducts
- endoscopic ligation of oesophageal and gastric varices

These methods help reduce or eliminate symptoms such as dysphagia, nausea, vomiting, constipation, and pain syndrome, and they also create conditions for enteral nutrition.

Radiotherapy

Radiotherapy holds an important place in palliative medicine and is used to eliminate or prevent severe symptoms associated with tumour progression.

Its role in improving quality of life is well established:

Brain metastases – improved physical activity, reduced pain

Bone metastases (including those complicated by pathological fractures) – improved mobility, reduced pain

Tumour- related spinal cord compression – improved mobility and restoration of pelvic organ function

Compression or obstruction of hollow organs – reduction and prevention of constipation, bowel obstruction, nausea, vomiting, and pain

Ulcerated or bleeding tumours, especially when surgery is not possible

Simple, accessible, and cost- effective conventional radiotherapy techniques exist that can rapidly relieve severe symptoms in the terminal stage of disease.

Respiratory Support

Respiratory support (invasive and non- invasive), comprising a range of methods that ensure adequate lung ventilation, is prescribed according to medical indications regardless of the aetiology of acute or chronic respiratory failure.

Sympathetic Blocks

Sympathetic nerve blocks are used in cases of uncontrolled (refractory) chronic pain that does not respond to pharmacotherapy.

Physical Methods

Physical methods can reduce pain syndrome, decrease intoxication, sanitise disintegrating tumours, and promote the epithelialisation of trophic ulcers.

Given the above, the necessity and appropriateness of using the listed instrumental methods to improve the quality of life of patients - while considering

the indications and contraindications for their use in various palliative care settings - are beyond doubt.

The choice of tactics in providing palliative medical care depends on the physician's knowledge and skills, the level of clinical reasoning and professional experience, as well as the availability and feasibility of using particular instrumental diagnostic and therapeutic methods.

The selection of a specific therapeutic approach is determined by the cause of the pathological symptom, its severity, the general condition of the patient, and their functional capabilities. To optimise decision- making in PMC, a syndrome- based approach is advisable.

It is appropriate to use the following instrumental diagnostic methods when providing PMC to oncology patients:

- Laboratory diagnostics
- Functional diagnostics
- Radiological examinations
- Endoscopic examinations

According to available data, pain is the second most common symptom after weakness.

In 85–90% of oncology patients requiring PMC, pain can be controlled with systemic pharmacotherapy using analgesics and adjuvant medicines.

However, in 10–15% of cases, interventional pain management techniques become necessary (epidural and spinal analgesia, radiofrequency neuroablation, epidural neurostimulation, etc.), due to the specific pathophysiological mechanisms of chronic pain and the development of so- called "pathological" pain.

Treatment of dyspnoea in oncology patients requiring PMC is based on understanding its underlying causes, which may include airway obstruction, metastatic involvement of lung tissue, pleural effusion, and others.

Pharmacological treatment does not always relieve dyspnoea; in such cases, respiratory support and other instrumental PMC methods may be used, such as

tracheal and bronchial stenting, tracheostomy, thoracocentesis, photodynamic therapy, and others.

Quality of life can be significantly improved by oesophageal or gastric stenting, gastrostomy, or photodynamic therapy.

Intestinal obstruction often requires surgical treatment, which may be contraindicated in weakened patients; in such cases, intestinal stenting may serve as an alternative.

Ascites also worsens quality of life and may cause pain, vomiting, and dyspnoea; the patient's condition can be alleviated through paracentesis.

When curative treatment is no longer feasible and eradication of the underlying disease is impossible, the patient should receive targeted symptomatic therapy, with mandatory assessment of its effectiveness to ensure timely adjustment of interventions as the condition evolves.

When a decision is made regarding the use of instrumental PMC methods, the patient is referred to a specialised PMC department of a multidisciplinary hospital or a palliative care centre, where multidisciplinary support can be provided.

In a number of cases, and in the absence of contraindications, invasive PMC methods may be performed in day- care settings (for example, paracentesis, epidural anaesthesia, photodynamic therapy, etc.), where patients can remain under medical supervision for several hours after the procedure.

It is inappropriate to refer such patients to a hospice, where diagnostic investigations and most medical interventions - even minimally invasive ones - are not provided.

The study results indicate that 20.24% (CI95% 18.81–21.73%) of patients require specialised palliative medical care in a PMC department, while 6.64% (CI95% 5.77–7.59%) require inpatient hospice care.

The need for specialised PMC, determined on the basis of the necessity for minimally invasive interventions to improve quality of life, amounted to 15.82% (CI95% 14.52–17.18%) of all respondents.

The lower limit of the 95% confidence interval (14.52%) allows us to assert that no fewer than 14.52% of oncology patients in clinical groups II and IV require specialised palliative medical care.

MAJOR SYNDROMES AND EMERGENCY CONDITIONS IN INCURABLE PATIENTS

1. Gastrointestinal Disorders:

- Nausea, vomiting
- Dysphagia
- Diarrhoea
- Constipation
- Hiccups
- Nutritional depletion
- Cachexia
- Intestinal obstruction.

2. Respiratory System Disorders:

- Respiratory impairment due to narrowing of the tracheobronchial tree
- Pneumonia
- Pleuritis
- Secondary pulmonary hypertension due to massive metastatic involvement of the lungs.

3. Cardiovascular System Disorders:

- Arrhythmias
- Pericarditis
- Haemodynamic disturbances due to impaired cardiac pump function
- Superior vena cava syndrome
- Pulmonary embolism.

4. Nervous System Disorders:

- Laryngeal paresis; Horner’s syndrome

- Brain metastases
- Pain syndrome.

5. Psychiatric Disorders:

- Agitation and anxiety
- Sleep disturbances
- Dementia
- Depressive disorders.

6. Fever.

7. Haemorrhage.

MANAGEMENT OF THE MAIN SYNDROMES THAT MAY OCCUR IN INCURABLE PATIENTS

Management of the main syndromes that may occur in incurable patients is shown in Tables 3-26.

Table 3

Nausea and Vomiting [1]

Clinical manifestations	Treatment and adult dosages	Home- care recommendations for relatives
Nausea and vomiting	Metoclopramide 10 mg intracutaneous TID, haloperidol 1-2 mg PO once a day or chlorpromazine (PO) 25-50 mg every 6 - 12 h, diphenhydramine 25-50 mg 2-3 times a day	• Offer foods that the patient likes and that are less likely to provoke nausea. • Feed and give fluids frequently, in small portions, and slowly. • Call a doctor if vomiting lasts for more than a day, or if the patient has a dry tongue, produces little urine, or develops abdominal pain.**
Nausea and vomiting caused by impaired intestinal passage due to tumour obstruction	Clemastine (PO) 1 mg BID or Cetirizine (PO) 10 mg once a day	

Table 4

Oral Mucosal Ulcers and Pain on Swallowing [2]

Clinical Manifestations	Treatment and Adult Dosages	Home- Care Recommendations for Relatives
Various ulcerative lesions of the oral mucosa (when the causative agent is unknown)	Rinse the mouth with a Betadine solution.	Gently remove plaque from the teeth, gums, tongue and palate using a soft toothbrush. Offer the patient saline mouth rinses (a pinch of salt in a glass of water) after meals and before bedtime, 3–4 times a day.
Oral candidiasis	Miconazole, lozenges: taken once daily for 7 days. Fluconazole: an initial 200 mg oral dose followed by 100 mg once a day for 10-14 days or until symptoms resolve.	• Local anaesthetics may help relieve the patient's discomfort. • Dissolve aspirin tablets in a glass of water and use the solution as a mouth rinse up to several times a day. • Provide analgesics if needed. • Food debris should be removed with a gauze swab moistened in saline. • Diet: – soft foods cause less discomfort; – puréed and liquid foods are easier for the patient to swallow; – avoid giving food that is very hot, very cold, or spicy.*
Aphthous stomatitis	Prednisolone: crush the tablet and apply a small amount of the powder directly to the ulcers. Dexamethasone solution used as a mouth rinse. Triamcinolone cream for topical application to ulcers, as well as solutions containing chlorhexidine or tetracycline, and local applications with lidocaine or benzocaine gel.	
Herpetic stomatitis	Acyclovir 400 mg PO. Metronidazole used as a mouth rinse (2 tablets crushed and dissolved in water). Mouth rinsing with a Betadine solution	

Unpleasant mouth odour caused by oral mucosal cancer or other oral cavity lesions	Metronidazole used as a mouth rinse (tablets crushed and dissolved in a glass of water).	

Table 5

Diarrhoea [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Diarrhoea	• Increase fluid intake to prevent dehydration. • In cases of severe diarrhoea, administer an oral rehydration solution (Gastrolit, Rehydron). • Provide therapeutic nutrition. • Dehydration prevention	• Encourage plenty of fluids to compensate for water loss. • Increase the frequency of meals and offer small portions. • Provide perianal skin care after each bowel movement: – avoid wiping with toilet paper; use a soft cloth instead; – wash the perianal area with soap and water three times a day; – if the patient experiences pain during defecation, apply petroleum jelly to the perianal area. • Call a doctor if the patient has: – vomiting and fever; – stools containing traces of blood; – diarrhoea lasting more than five days; – increasing weakness; – skin damage around the anus.
Diarrhoea in the absence of fever, blood in the stool, and in patients who are not elderly	Antidiarrhoeal agents such as Loperamide may be used, starting with 4 mg PO as an initial dose followed by additional 2 mg PO doses after each bowel movement. • If diarrhoea is a symptom of opioid withdrawal, morphine 2,5-5 mg PO may be used every 6-8 h with gradually decreasing doses according to a tapering schedule.	
Perianal tenderness	Apply an anaesthetic ointment (e.g., lidocaine) or petroleum jelly to soothe the skin.	
Faecal Incontinence	Use petroleum jelly to protect the perianal skin.	

Table 6

Dry Mouth [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Dry mouth	Review the prescribed medications (dry mouth may be a side effect of the drugs being taken).	• Offer frequent sips of fluids. • Provide water for regular moistening of the oral cavity. • Give the patient small pieces of fruit to suck, such as orange or lemon
Serious complications caused by insufficient saliva production	Refer the patient to a dentist.	

Table 7

Constipation [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Faecal Impaction	Perform a digital rectal examination and remove impacted stool	**• Offer fluids frequently. • Add more fruit (including dried fruit), vegetables, oatmeal, and soft foods to the diet. • Give a tablespoon of vegetable oil before breakfast. • Gently insert petroleum jelly or a small piece of soap into the patient's rectum if they cannot do this themselves, using medical gloves
Other Causes of Constipation	Laxatives: On the 1st day, use a bulk-forming laxative such as Bisacodyl 5-15 mg in the bedtime, Senna (starting with an initial dose (2 tabl 7,5 mg BID) and increasing to 2 tabl every 4 h as needed), Or laminaria taken orally after meals. On the second day, use a stimulant laxative to enhance intestinal peristalsis, such as Isaphenin 10 mg taken orally after meals BID or 20 mg at bedtime.	

Table 8

Vaginal Discharge Caused by Cervical Cancer [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Vaginal discharge caused by cervical cancer	Metronidazole, vaginal tablets, administered 500 mg once daily intravaginally for 10-20 days. Antihistamines: Diphenhydramine 30-50 mg taken 1-3 times daily, Or Promethazine 25 mg taken 2-3 times daily after meals	Ensure daily hygiene

Table 9

Insomnia [4]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Insomnia The causes of insomnia may include pain, anxiety, depression, or withdrawal syndrome (from opioids or diazepam).	Bromisoval 600-900 mg taken orally half an hour before sleep. Diazepam 5-10 mg PO taken at night (preferably not prescribed long-term, as it may cause depression). Lorazepam 0,5-1 mg PO taken at night, with a maximum 4 mg daily limit	• Talk with the patient about the worries that prevent them from falling asleep and provide reassurance. • Ensure quiet conditions whenever possible. • Avoid giving strong tea or coffee at night. • Treat pain if necessary.

Table 10

Hiccups [2]

Clinical Manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Gastric Distension in the Late Stage of a Malignant Tumour	Simethicone 65-125 mg taken orally, up to a 500 mg maximum daily amount	Ways to Stop Hiccups • quickly eat two teaspoons of sugar; • drink cold water; • eat crushed ice; • massage the palate with a clean handkerchief (towards the soft palate); • hold the breath or breathe into a paper bag, stopping if discomfort appears; • pull the knees to the chest and lean forward (compressing the chest); • drink from the "wrong" side of the glass; • drink aerated water (swallowing air) or peppermint water (which relaxes the oesophageal sphincter); • massage the external auditory canal (to stimulate sneezing) or provide nasopharyngeal stimulation (nasal swab, nasogastric tube); • breathe into a paper bag.
Persistent Hiccups	Metoclopramide 10-20 mg taken orally 2-3 times per day, Or Haloperidol 0,5-2 mg taken orally 1-3 times per day.	
Brain Tumour	An antiepileptic medicine may also be effective (such as Carbamazepine ½ tabl PO taken 1-2 times per day after meals, Or Phenytoin, which is initiated with a 15-20 mg/kg loading dose followed by a maintenance 5-6 mg/d dose). Alternatives to Phenytoin include Sodium valproate, Clonazepam, or Phenobarbital.	

Table 11

Fever [2]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Fever	• Identify and eliminate the cause. • Paracetamol 500 mg PO (not exceeding 4 g the recommended maximum daily amount) or Acetylsalicylic acid 650 mg PO every 4 h. • Prevent dehydration. • Metamizole in a low dose. • Cimetidine 400 mg taken at night may prevent fever in some patients with Hodgkin's lymphoma.	• Offer the patient drinks frequently: water, weak tea, fruit juices. • Make small adjustments to the daily routine (changing bed linen, using a hairdryer for comfort, gentle wiping).

Table 12

Anxiety, Agitation [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Mild Anxiety and Agitation	• Identify the cause. If these symptoms appear for the first time, rule out cognitive impairment. • In cases of pronounced anxiety, tranquillisers may be considered. • Suggest anxiety- relief strategies appropriate to the specific situation. • Teach relaxation techniques. • Listen to the patient attentively and provide psychological support. • Ensure that the patient has adequate supervision and psychosocial support.	Support for Anxiety • Listen to the patient attentively. • Discuss the issues that worry them in a confidential setting. • Help the patient calm down using methods such as: – gentle, calming music; – massage; – praying together.

Mildly expressed anxiety and agitation	• Prescribe Diazepam 2,5-5 mg at night or BID for a short time - it is rarely needed if the patient receives adequate supervision (avoid long- term use, as it may cause depression). • If manic- depressive psychosis is suspected, refer the patient to a psychiatrist for assessment and treatment	
Severe anxiety or agitation, delirium	Haloperidol 5-10 mg taken PO or IV; Diazepam 5-10 mg taken PO (in the case of delirium 20 mg) or 5 mg administered IM or IV (the IM injection may be painful; IV administration should be slow when possible). Midazolam has the advantage of being suitable for continuous subcutaneous infusion and can also be mixed with Morphine in the same syringe. It is usually started with 2,5-10 mg subcutaneous dose, with further 2 h dosing adjusted to 10-20 mg/d according to clinical effect	

Table 13

Muscle Stiffness and Contractures [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Muscle stiffness and contractures	Assess the range of movement; if marked contracture or muscle spasms are present, consider prescribing:	• Do not force the patient to remain on bed rest; instead, encourage movement. • If the patient is immobile, perform a simple

	• Diazepam 5-10 mg PO 2-3 times per day (avoiding long- term use, as it may cause depression); • Baclofen 5-10 mg PO with meals 2-3 times per day; • Lorazepam 1 mg PO 2-3 times per day; Or • Tetrazepam 50 mg/d PO, with the dose increased till 200 mg/d if necessary and reduced gradually when discontinuing.	range- of- motion exercise routine at least twice daily: – gently bend, straighten and move the joints through motions that can be done without effort. Be careful and perform movements slowly, without causing pain; – to avoid injuring the joint, support the limb above and below the joint during movement; – stretch the joints by applying steady, even pressure and holding the position as described above; – bring the patient's arms behind their head and lift their legs to a right angle; ask the patient to lift their legs as much as they can on their own first, then assist them. • Provide regular massage.

Table 14

Caring for a Patient with Dementia [2]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
If symptoms appear for the first time: forgetfulness, impaired concentration, language and thinking difficulties, mood swings, antisocial behaviour (for example, walking around naked)	Assess the degree of confusion, speech disturbance and disorientation (rule out poisoning, hypoglycaemia and other systemic illnesses, alcohol or drug intoxication, medication toxicity, withdrawal syndrome; consider the possibility of HIV- encephalopathy). Treatment depends on the clinical presentation. A	• The patient should live in familiar surroundings for as long as possible: • keep objects in their usual places so the patient can find them; • maintain a familiar daily routine; • remove dangerous items; • use simple phrases; ensure that only one person speaks at a time;

	psychiatric consultation is essential.	• reduce background noise (television, radio); • the patient must remain under constant supervision.
Paranoid states or night- time agitation	• Haloperidol 5-10 mg . • Lorazepam 0,5-1 mg taken PO, with the total daily amount 4 mg adjusted as clinically required.	

Table 15

Depression [1]

Clinical Manifestations	**Treatment and Recommendations**	
Warning symptoms: hopelessness, insomnia, loss of interest in life. Symptoms of depression: • sadness, low or depressed mood • reduced interests • fatigue If any of the above symptoms are present, ask the patient whether they have: • sleep disturbances • changes in appetite • impaired concentration • reduced libido • psychomotor slowing • feelings of worthlessness or low self- esteem • thoughts of suicide or death • feelings of guilt If 5 or more of these symptoms persist for more than 2 weeks, the diagnosis is Major Depression.	Assessment and Management: Evaluate suicide risk and clarify the diagnosis: major depression, minor depression, complicated grief reaction, or severe distress (e.g., bereavement). If bipolar disorder is suspected, ensure psychiatric consultation to determine whether lithium therapy is appropriate. If bipolar disorder is not present, an antidepressant may be considered (Amitriptyline 25-50 mg BID with the gradually increasing till 300 mg/d	Support for the Patient: The patient requires support; if there is a risk of suicide, they must not be left alone. Counselling: Major Depression: • explain to the patient and their relatives the need for medical treatment • ensure psychiatric consultation • provide ongoing monitoring Minor depression or complicated grief reaction: • provide counselling • treat insomnia if needed • monitor the patient

If fewer than 5 symptoms are present, or if distress and maladaptation after a significant loss last for more than 2 months, the diagnosis is Minor depression or complicated grief reaction.		
If a patient, while in a depressive state, expresses suicidal thoughts, it is necessary to determine the level of suicidal intent: – is there a stated reason for the decision to end their life? – is the decision made without hesitation, or is there only a profound sense of despair and hopelessness? – is there a plan for carrying out the intention (method, place, time)? – what means does the patient plan to use, and have these been prepared?	If there is genuine suicidal intent (a plan and the means to carry it out), the patient must be urgently admitted to a specialised medical facility. If the patient's physical condition is severely compromised, ensure an emergency psychiatric consultation and continuous observation.	• Do not leave the patient alone if there is a risk of suicide. • Remove dangerous objects. • Involve family members and friends

Table 16

Itching [3]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Scabies, Itchy Dermatitis, Eczema, Dermatophytosis, Dry Skin, Psoriasis	• A topical glucocorticoid cream may be applied to non- infected, inflamed areas of skin. • Antihistamines may be used to reduce itching (Diphenhydramine 30-50 mg 1-3 times per day or Prometazine 25 mg 2-3 times per day after meals).	Measures that help reduce itching: • applying petroleum jelly to itchy areas • washing with water containing a small amount of vegetable oil (1 tbs per 5 l of water)

	• In cases of recurrent skin infections, irrigating the affected areas with a dilute chlorhexidine solution after bathing may be helpful. • If itching is caused by obstructive jaundice, treatment with a corticosteroid or haloperidol may be considered. • In eczema, gentle washing and careful drying of the skin are recommended. Short- term use of topical glucocorticoids may be appropriate (not on the face). • In dermatophytosis, apply Miconazole ointment or another antifungal cream. In extensive cases, Fluconazole 50-100 mg/d PO 7-14 days may be prescribed. • If scabies is suspected, treatment may be initiated even in the absence of typical signs. • In psoriasis, apply an ointment containing 5% tar and 2% salicylic acid; sunlight exposure for 30-60 min daily may be beneficial.	• wiping the skin after bathing with a 0,05% chlorhexidine solution • taking warm baths

Table 17

Pressure Ulcers [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Pressure ulcers, signs of infection and other complications	*Skin care to prevent pressure ulcers is essential for all patients.* • Ensure that there are no other sources of infection. • If the skin is red, painful, warm to the touch, or if there is pus or crusting, fever or other general symptoms, or if the infection is spreading to the muscles, the patient must be hospitalised and given antibiotics intravenously, intramuscularly or orally. • If the damaged area of skin is larger than 4 cm, or if there are red streaks, painful nodules, or more than 2 affected sites: prescribe antibiotics; if fluctuation is present, drain the abscess; elevate the limbs; review the patient the following day. • If the skin is red, warm and painful but there are no other symptoms, wash the affected areas with an antiseptic; if fluctuation is present, drain the abscess; review the patient in 2 days.	*The following measures help reduce pain and speed up the healing of pressure ulcers* • Gently wash small damaged areas with salted water and allow them to dry. • If the ulcer is shallow, leave the wound open. • For pain, give analgesics regularly, such as paracetamol or aspirin. • Deep or large pressure ulcers should be gently treated with honey daily to aid cleansing, and covered with a clean, light dressing to promote healing. • If there are any changes in skin colour or if the ulcer worsens, ensure medical consultation. *Prevention of Pressure Ulcers in Bedridden Patients* • Whenever possible, sit the patient up in a chair from time to time. • When sitting the patient up in bed, lift them by the shoulders and place a pillow behind them rather than pulling them towards the head of the bed, to avoid skin damage.

Tumours or Ulcers with an Unpleasant Odour	Sprinkle the affected area with metronidazole powder (a crushed tablet).	• Change the patient's position frequently (ideally every 1–2 hours); use pillows and rolls to support the position. • Bed linen must always be clean and dry. • Place very soft fabric under the patient, such as a soft cotton towel. • Ensure hygiene of the external genitalia and perineum. • After bathing, gently pat the skin dry with a soft towel. Apply cream, lanolin, cosmetic or vegetable oil to the skin. • If the patient has urinary or faecal incontinence, place a waterproof sheet under the bed linen to keep the bed dry. • Massage the back, thighs, elbows and ankles with petroleum jelly. • If the patient has urinary or faecal incontinence, apply a protective layer of petroleum jelly to the skin of the perineum, back, thighs, ankles and elbows. • During urination and defecation, support the patient over the bedpan to prevent skin damage and soiling of the bedding.

Table 18

Urinary and faecal incontinence [2]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Urinary Incontinence	Boys and men may be fitted with urine collection devices. Girls and women may have a urinary catheter inserted.	• Change underwear and pads regularly. • Keep the skin clean and dry, apply protective ointments.
Faecal Incontinence	Loperamide may be used to achieve formed stools (specific dosing not translated for safety reasons)	

Table 19

Cough and Shortness of Breath [4]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Terminal stages of lung cancer, pulmonary complications of HIV infection, or other lung diseases Shortness of breath associated with bronchospasm.	Treatment of Bronchial Asthma. Inhalations of salbutamol 2,5-5 mg for 10-15 minutes at 4-6 h. Long- acting xanthine derivatives (such as Theophylline or Aminophylline) may be used. Prednisolone 40-60 mg/d or Dexamethasone 8-12 mg/d may be prescribed, with the dose gradually reduced after several days.	*Simple Cough* •Home remedies: honey, lemon, steam inhalations (for example, with eucalyptus tincture). •If a productive cough develops and persists for more than 3 weeks, tuberculosis is possible. A doctor should be called. *Shortness of Breath* •Help the patient take a position that makes breathing easier (usually sitting, sometimes sitting with a slight forward lean, with the hands resting on a table). •Place pillows behind the patient's back. •Ensure access to fresh air: open a window, fan the patient. •If the sputum is thick, offer fluids more frequently (this helps sputum clearance).
Shortness of breath associated with heart failure or oedema.	Morphine PO or Tramadol in low doses, furosemide 40 mg, may be administered as part of symptom management.	
Cough with thick, viscous sputum	Inhalations with normal saline can be used to ease breathing discomfort.	
Abundant watery sputum.	Hyoscine butylbromide 10 mg every 8 h (an anticholinergic agent)	

Large amounts of sputum (more than 30 ml per day).	• Breathing exercises (such as coughing with an open glottis) and postural drainage can be helpful. • Suctioning sputum from the trachea should be used only as a last resort, as the procedure is uncomfortable for the patient. • Haloperidol can help dry the airways due to its anticholinergic effect.	*Sputum Handling Rules* •Handle sputum carefully to avoid spreading infection. •Provide the patient with a jar with a lid for expectoration. •Empty the jar into the toilet, then wash it with disinfectant or rinse with boiling water. Home remedies: honey, lemon, steam inhalations (for example, with eucalyptus tincture). • If a productive cough develops and persists for more than 3 weeks, tuberculosis is possible. A doctor should be called.
Exhausting cough: if a productive cough persists for more than 3 weeks, perform three sputum examinations for Mycobacterium tuberculosis.	•Morphine 2,5-5 mg PO and Lidocaine administered as inhalations can reduce shortness of breath and are particularly effective for an irritating cough. It is advised not to eat or drink for 30-60 min after using these medicines. •Treatment of tuberculosis should follow the protocol for managing opportunistic infections in people with HIV/AIDS. •Patients receiving anti- tuberculosis therapy should continue their treatment to avoid transmitting the infection to others.	
Education	Teach the patient how to use the reserve capacities of the respiratory system.	

Table 20

Fatigue [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Exhaustion in a dying patient when cared for at home.	Prednisolone, 5–15 mg per day orally (used to stimulate appetite). Cyproheptadine and Metoclopramide may reduce anorexia, but they do not affect the metabolic causes of cachexia. Progestogens may have an anabolic effect and increase body weight, but their impact on survival has not been established.	•Encourage the patient to take food, but do not insist, as the body may be unable to cope with it and vomiting may occur. •Feed the patient frequently with small portions; prepare food that the patient enjoys. •Do not cook food near the patient. •Keep in mind that as the illness progresses, the patient will eat less and less. Food supplements aimed at maintaining or increasing caloric intake, such as enriching ordinary food with sugar or cream, may help achieve this. Nutritional supplements generally contain mainly proteins and carbohydrates; the choice between different products depends on the patient's taste. The use of multivitamin supplements will do no harm and may be acceptable to the patient and their family.

Table 21

Pneumonia [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
1. Paraneoplastic pneumonia	The treatment of paraneoplastics pneumonia should begin with protected penicillins or	See the recommendations for cough and shortness of breath.

2. Obstructive-type pneumonia 3. Abscess-forming pneumonia associated with tumour breakdown	fluoroquinolones, with mandatory addition of third- or fourth- generation cephalosporins in elderly patients, in cases of lung cavitation, or when aspiration pneumonia is suspected. It is advisable to take into account the results of sputum culture and antibiotic sensitivity testing. Reserve antibiotics should be selected according to the antibiogram. The use of tumour recanalisation techniques to restore the patency of the tracheobronchial tree accelerates the stabilisation of the patient and the initiation of specific oncological treatment.	
4. Aspiration pneumonia caused by aspiration of food or gastric contents	The treatment of aspiration pneumonia resulting from the aspiration of gastric contents requires scheduled bronchial sanitation procedures with endobronchial administration of glucocorticoids and antibiotics, along with systemic glucocorticoids.	
5. Aspiration pneumonia associated with oesophagobronchial fistulas	Conservative treatment of aspiration pneumonia caused by the presence of fistulas is generally ineffective without surgical or endoscopic correction, which may include: - Placement of a gastrostomy - Stenting with covered stents **Such treatment may be carried out as part of preoperative preparation and requires:**	

	- Exclusion of oral food intake; - Administration of Atropine 0,3 ml SC 2-3 times per day; - Tube feeding with balanced nutritional formulas (such as Berlamin); - Correction of protein deficiencies (Amilon 10% 500 ml 1-2 times per day); - Correction of hypoalbuminaemia (Lactoprotein 200 ml 1-2 times per day) - Compensation for energy losses with intravenous carbohydrate solutions (Gluxil 100 ml IV 3-4 times per day) - Correction of electrolyte disturbances (such as Trisol, Quadrosol, or Ringer's solution)	

Table 22

Secondary pulmonary hypertension [2]

Clinical manifestations	**Treatment and adult dosages**
Secondary pulmonary hypertension due to extensive metastatic involvement of the lungs	A severe condition with a poor prognosis. **The corrective measures should include:** - Inhalations with humidified oxygen - Furosemide 2 ml administered IM in the morning; - Torasemide 3 ml administered IV by slow injection once daily; - Spironolacton 100 mg taken in the morning; - Dexamethasone 12-16 mg given in divided doses throughout the day; - L- lysine aescinate 5-10 ml administered IV in a 50 ml saline solution; - Berlipril 5 mg taken once or twice daily - Isosorbide dinitrate 10-20 mg taken once or twice daily; - Serratiopeptidase 1 tabl TID; - Enoxaparin 0,2 ml or Bemiparin 2500 U SC once daily; - Antibiotics as indicated;

	- Cetirizine 1 tabl BID.

Table 23

Pleuritis [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
1. Complications of pneumonia	Treatment of the underlying disease with the use of antibiotics, anti- inflammatory agents and anti- oedema therapy. Removal of the pleural exudate with intrapleural administration of an antibiotic.	See the recommendations for cough and shortness of breath.
2. Lymphatic obstruction in the mediastinum		
3. Tumour invasion of the visceral pleura	Clarification of the diagnosis is possible only through thoracoscopy. This does not apply to advanced cases, and depending on the nature of the tumour, surgical treatment may be indicated. Removal of the exudate is performed to restore lung volume and to correct respiratory complications.	
4. Metastatic involvement of the pleura and mesothelioma	When the diagnosis is established and palliative treatment is declined, periodic thoracentesis or placement of an intrapleural micro- drain is required to preserve lung ventilation volume. As part of palliative management, the following may be considered:	

	- Sclerosing therapy with Bleomycin 60 mg administered into one pleural cavity; - Hyperthermic intrapleural chemotherapy with Cisplatin 50 mg, performed twice weekly for up to 3 sessions; - Talc pleurodesis for pleural cavity sclerosis.	

Table 24

Arrhythmia [1]

Clinical manifestations	**Treatment and adult dosages**
Atrial fibrillation with ventricular arrhythmia, tachysystolic form Supraventricular tachycardia	Digoxin 0,00025 g taken once daily. Selective β- blockers may be added, with dose titration as needed. If there is no effect, Amiodarone 200 mg 2 tabls TID may be introduced, with a subsequent reduction to a maintenance dose (200 mg/d).
Sinus tachycardia	With normal or low blood pressure, Ivabradine 5-7,5 mg may be used twice daily. With elevated blood pressure, the drugs of choice are selective β- blockers such as Bisoprolol 10 mg/d.

Table 25

Pericarditis [1]

Clinical manifestations	**Treatment and adult dosages**	**Home- care recommendations for relatives**
Tumour invasion into the pericardium Pericardial metastasis Post- radiation complication	***Basic therapy for heart failure:*** - Furosemide 2 ml IM or 40 mg PO; - Torasemide 3 ml IV; - Enalapril 5 mg taken once or twice daily; - Isosorbide dinitrate 20 mg BID;	Reducing the amount of fluid you consume (drinks, soups, fruit) and limiting beverages that contain caffeine or alcohol. Reducing the amount of table salt you use and avoiding foods with hidden salt content (cheese, sausages, processed

	- Spironolactone 50-100 mg taken daily. Treatment must always take into account the underlying cause of the heart failure.	foods, etc.). To improve flavour, use herbs and spices instead of salt. Weigh yourself 1–2 times a week, at the same time of day, preferably in the morning on an empty stomach and without clothes, always using the same scales. Contact a doctor if your weight increases by more than 2 kg between weighings. Monitor your blood pressure and pulse.

Table 26

Superior Vena Cava Syndrome [1]

Clinical manifestations	**Treatment and adult dosages**
Superior vena cava syndrome is a severe complication caused by compression of the major mediastinal vessels by a tumour. It presents with swelling of the face, neck, arms, and upper torso, accompanied by dilation of subcutaneous veins. Without timely treatment, cerebral oedema may develop.	**Treatment should include anti- oedema therapy and decompressive radiotherapy in an oncology centre.** Medications that may be used as part of supportive management include: Diuretics administered by various routes: - Furosemide 2 ml IM in the morning, - Torasemide 3 ml IV slow once a day, - Spironolacton 100 mg in the morning, Steroids given in divided doses: - Dexamethasone 12-16 mg/d 2-3 times; Agents that reduce vascular permeability: - L-lysine aescinate 5-10 ml IV 1-2 times per day in 50 ml of saline solution; Antihypertensive medicines as needed: Enalapril 5-10 mg PRN; Antianginal medicines: isosorbide dinitrate 10-20 mg 1-2 times per day; Enzymatic anti- inflammatory agents: Serratiopeptidase 1 tabl TID; Anticoagulants administered subcutaneously: Enoxaparin 0,2 ml or Bemiparin 2500 U SC; Antibiotics when indicated;

	Antihistamines: Cetirizine 1 tabl BID.

TRAINING OF FAMILY MEMBERS AND THE SOCIAL WORKER IN CARING FOR THE PATIENT AT HOME

Teach family members or the social worker how to manage different symptoms. During one visit, explain only a few symptoms or demonstrate a few techniques.

- First, explain the symptoms and teach the techniques that are most relevant in this particular situation.
- Clearly demonstrate how to perform therapeutic exercises correctly, or how to measure an accurate dose of a liquid medication. Check the level of acquired knowledge and skills by asking them to demonstrate a technique or answer a question to confirm understanding.
- Encourage them to contact you for advice if any questions or difficulties arise.
- Make sure the relatives know where and to whom they can turn for help. Explain what options exist for patient care if they are unable to continue caring for the patient at home.

Additional methods for relieving pain:

- Psychological support.
- Physical methods: massage (stroking, gentle rubbing, rocking, vibration); cold or heat; deep breathing.
- Psychological methods: distraction, music, meditation.
- Prayer (respect the patient’s religious beliefs).

TEST QUESTIONS FOR SELF- STUDY AND SELF- ASSESSMENT OF THE FINAL LEVEL OF KNOWLEDGE

1. At which stage do oncology patients most often experience severe pain?

A. Stage 1

B. Stage 2

C. Stage 3

D. Stage 4

E. At all stages

2. The aim of palliative care is to relieve the suffering of a patient who is:

A. Incurable

B. Oncological

C. HIV- infected

D. Suffering from malignant neoplasms

E. Experiencing complications from specific treatment

3. The “gold standard” for assessing a patient’s health status is:

A. The patient’s own description of sensations and experiences

B. Choosing a strategy to relieve suffering

C. Carrying out complex diagnostics

D. Assessing the patient’s emotional state

E. Interviewing the attending physician

4. Disorientation is:

A. Confusion

B. Anxiety

C. Disturbance

D. Wakefulness

E. Apathy

5. In its policy statement on the treatment of terminally ill patients experiencing chronic pain (1990), the World Medical Association recommended that care for the terminally ill should be provided in such a way:
A. That they can live as actively as possible until death
B. That their suffering is maximally relieved and a dignified death is supported
C. That it neither seeks to hasten nor postpone death
D. That pain and other distressing symptoms are relieved
E. During radical treatment

6. Problems faced by incurable patients include:
A. Lack of funds to purchase medicines
B. Insufficient availability of opioids
C. No problems at all
D. Lack of chemotherapy drugs
E. Lack of radiotherapy equipment

7. WHO experts believe that the key principles of palliative- care development programmes should be:
A. Palliative care is an urgent humanitarian need worldwide for people with terminal illnesses
B. Palliative care should be integrated into the existing healthcare system
C. Palliative care should be provided only in oncology institutions
D. Palliative care should be guaranteed for all population groups, regardless of religion or beliefs
E. Correct answers: A, B, D

8. A hospice is:
A. A paid institution providing care for a seriously ill person
B. A free state institution providing care for a seriously ill person

C. A paid institution providing care for a seriously ill person, relieving physical and psychological suffering, and supporting social and spiritual needs

D. A free state institution providing care for a seriously ill person, relieving physical and psychological suffering, and supporting social and spiritual needs

E. A free state medical institution providing the full range of anti- tumour therapy

9. What is the basis for successful palliative care?

A. Long- term professional continuous observation of the patient

B. Professionalism of the staff

C. The patient's willpower

D. Availability of necessary medications

E. Full provision of radical treatment

10. What idea lies at the heart of the hospice concept?

A. Bringing all patients together in one place

B. Providing palliative care

C. Isolating patients from society

D. Helping the patient's relatives

E. Solving social and domestic problems

11. Palliative treatment is aimed at solving several tasks:

A. Ensuring reduction of pain and relief of other distressing symptoms

B. Providing psychological and spiritual support to the patient

C. Offering a system that helps the patient maintain the ability to live as actively as possible for as long as possible

D. Correct answers: A, B, C

E. All of mentioned above

12. A synonym for the term “incurable patient” is:

A. Incurable patient

B. Suffering patient

C. Dying patient

D. Oncological patient

E. Receiving long- term treatment

13. The main goal of palliative care is:

A. Improving the quality of life of the patient and their family

B. Relief of suffering

C. Prolongation of life

D. Addressing physical and psychosocial problems

E. Improving social and domestic conditions

14. An independent branch of palliative care, whose leading component is the development of a special philosophy and the organisation of psychological support for the patient and their family, is:

A. Medical care

B. Palliative treatment

C. Hospice care

D. Volunteer movement

E. Anti- tumour therapy

15. A very important component of palliative care is:

A. Relief of pain syndrome

B. Active comprehensive support for patients

C. Implementation of measures ensuring adequate pain control

D. Psychosocial and spiritual support of the patient

E. Completion of a full course of specific treatment

16. Palliative care for patients should begin at the moment:

A. When a diagnosis of an incurable disease is established

B. When patients experience physical or other types of suffering

C. When the disease progresses and enters the terminal stage

D. When specialised palliative care is required

E. When a diagnosis of a malignant disease is established

17. Palliative care is:

A. An approach that improves the quality of life of patients and their families facing life- threatening illness

B. Prevention and relief of suffering through early identification, thorough assessment, and treatment of pain and other physical symptoms

C. Provision of psychosocial and spiritual support to the patient and their relatives

D. Qualified medical care for terminally ill patients aimed at relieving, and when possible preventing, pain and other severe symptoms accompanying dying

E. Qualified comprehensive anti- tumour therapy involving specialists of all fields

18. Life- supporting treatment includes:

A. Artificial ventilation, extracorporeal dialysis using a “artificial kidney” machine, artificial nutrition

B. Relief of severe symptoms

C. Pain control

D. Psychological support

E. Improvement of social and material conditions

19. Combating oncological diseases involves:

A. A philosophical approach

B. Prevention and early detection

C. Hygienic measures

D. Preventive actions

E. Active therapeutic measures

20. What is the main goal of palliative care?

A. Conducting a full examination

B. Treating everyone without exception

C. Ensuring that all patients who need it receive it

D. Carrying out radical treatment

E. Correction of complications of specific treatment

21. What is the basis for successful palliative care?

A. Long- term professional continuous observation of the patient

B. Professionalism of the staff

C. The patient's willpower

D. Availability of necessary medications

E. Full provision of radical treatment

22. A 68- year- old patient is diagnosed with squamous cell carcinoma of the oesophagus with multiple metastatic lesions in the lungs, regional lymph nodes, and mediastinal lymph nodes, stage IV, T3N3M1. Choose the treatment strategy:

A. Radical treatment

B. Radical surgical treatment

C. Radical polychemotherapy

D. Palliative treatment

E. Radiotherapy

23. A 55- year- old patient is diagnosed with oesophageal adenocarcinoma with metastatic involvement of regional lymph nodes, stage III, T2N1M0. Choose the treatment strategy:

A. Radical surgery only

B. Combined treatment

C. Palliative treatment

D. Comprehensive treatment

E. Chemotherapy only

24. A 66- year- old patient is diagnosed with squamous cell carcinoma of the oesophagus with brain metastases, stage IV, T2N1M1. Choose the treatment strategy:

A. Radical treatment

B. Radical polychemotherapy

C. Radiotherapy

D. Palliative treatment

E. Comprehensive treatment

25. A 70- year- old patient is diagnosed with adenocarcinoma of the lower third of the oesophagus with regional lymph- node involvement, stage III, T4aN1M0, dysphagia grade 3, and severe concomitant cardiovascular insufficiency. Choose the treatment strategy:

A. Radical treatment

B. Radical surgical treatment

C. Comprehensive treatment

D. Palliative treatment

E. Combined treatment

26. A 60- year- old patient received radical treatment for oesophageal cancer; after one year, the disease recurred. Choose the further management strategy:

A. Palliative treatment

B. Surgical treatment only

C. Chemotherapy only

D. Radiotherapy only

E. Repeat radical treatment

27. A 50- year- old patient with oesophageal cancer shows disease progression during specific treatment. General condition remains satisfactory. Determine the further treatment strategy:

A. Continue radical treatment

B. Anti- relapse treatment

C. Comprehensive treatment

D. Provision of palliative care

E. Palliative treatment

28. A 75- year- old patient with progressive oesophageal cancer is admitted to a hospice. What care does he require?

A. Pain management

B. Enhanced nursing care

C. Spiritual support

D. Correct answers: A, B, C

E. Anti- tumour therapy

29. A 50- year- old patient with stage IV oesophageal cancer refuses anti- tumour therapy. Determine the management strategy:

A. Provision of social support

B. Ensuring regular medical consultations

C. Provision of palliative care

D. Correct answers: A, B, C

E. Hospitalisation in an oncology treatment facility

30. A 68- year- old patient is diagnosed with gastric cancer with multiple metastatic lesions in the lungs, regional lymph nodes, and mediastinal lymph nodes, stage IV, T3N3M1. Choose the treatment strategy:

A. Radical treatment

B. Radical surgical treatment

C. Radical polychemotherapy

D. Palliative treatment

E. Radiotherapy

31. A 55- year- old patient is diagnosed with gastric adenocarcinoma with metastatic involvement of regional lymph nodes, stage IIB, T2N2M0. Choose the treatment strategy:

A. Radical surgery only

B. Combined treatment

C. Palliative treatment

D. Comprehensive treatment

E. Chemotherapy only

32. A 66- year- old patient is diagnosed with gastric cancer with brain metastases, stage IV, T2N1M1. Choose the treatment strategy:

A. Radical treatment

B. Radical- mode polychemotherapy

C. Radiotherapy

D. Palliative treatment

E. Comprehensive treatment

33. A 55- year- old patient is diagnosed with colon cancer, stage I, T2N0M0. Choose the treatment strategy:

A. Radical surgery only

B. Combined treatment

C. Palliative treatment

D. Comprehensive treatment

E. Chemotherapy only

34. A 60- year- old patient received radical treatment for colon cancer; after one year, the disease recurred. Choose the further management strategy:

A. Repeat radical treatment

B. Surgical treatment only

C. Chemotherapy only

D. Radiotherapy only

E. Palliative treatment

35. A hospice patient reports painful discomfort, urinary retention, and constipation. What measures should be taken to relieve constipation?

A. Use of laxative therapy

B. Increased fluid intake and mobility

C. Laxative therapy, increased toilet visits, increased fluid intake and mobility

D. Increased toilet visits, increased fluid intake and mobility

E. Consumption of bran

36. A hospice patient is admitted with ascites. On examination: enlarged abdomen, shortness of breath with minimal movement. Which palliative treatment methods are required?

A. Treatment of the underlying cause, diuretics, abdominal paracentesis, peritoneovenous shunting

B. Abdominal paracentesis

C. Diuretics, peritoneovenous shunting

D. Treatment of the underlying cause, abdominal paracentesis

E. Peritoneovenous shunting, diuretics

37. General principles of chronic pain therapy according to WHO:

A. “By mouth”

B. “By the clock”, “by mouth”

C. “Stepwise escalation”, “individual approach”

D. “By the clock, by mouth, stepwise escalation, individual approach, attention to detail”

E. “By mouth”, “individual approach”

38. At the initial step of analgesia for chronic pain in palliative care, the following are used:

A. Non- opioid analgesics, adjuvant analgesics

B. Non- opioid analgesics, adjuvant analgesics, strong opioids

C. Weak opioids, adjuvant analgesics, anticonvulsants

D. Non- opioid analgesics, adjuvant analgesics, weak opioids

E. Strong opioids, anticonvulsants

39. Opioid analgesics include:

A. Paracetamol, Diclofenac, Cenkoxib, Ibuprofen

B. Tramadol, Morphine, Oxycodone, Naloxone

C. Prednisolone, Dexamethasone, Hydrocortisone

D. Pregabalin, Gabapentin, Tolperisone

E. Tizanidine, Taclophene, Duloxetine

40. The principle of “stepwise escalation” in pharmacological therapy of chronic pain syndrome:

A. Analgesics should be prescribed regularly according to a schedule based on the duration of action, without waiting for pain to appear.

B. Selection of analgesic drugs proceeds from non- opioid analgesics for mild pain, weak opioids for moderate pain, and strong opioid analgesics for severe pain, according to the WHO analgesic ladder.

C. The need for an individual selection of the most effective analgesic at the appropriate dose with the fewest side effects.

D. All injectable forms of analgesics should be avoided as much as possible.

E. Consideration of the patient's individual characteristics and monitoring of their condition.

1	2	3	4	5	6	7	8	9	10
D	**A**	**A**	**A**	**B**	**B**	**E**	**D**	**A**	**B**
11	12	13	14	15	16	17	18	19	20
D	**A**	**A**	**C**	**A**	**A**	**D**	**A**	**B**	**C**
21	22	23	24	25	26	27	28	29	30
A	**D**	**A**	**D**	**D**	**E**	**E**	**D**	**D**	**D**
31	32	33	34	35	36	37	38	39	40
A	**D**	**A**	**A**	**C**	**A**	**D**	**A**	**B**	**B**

SITUATIONAL TASKS

Case 1

A patient with stage IV lung carcinoma (T4N2M1) suddenly develops intense haemoptysis, general weakness, dizziness, and pallor. Pulse 120/min, thready. Blood pressure 80/40 mmHg.

Your actions?

Case 2

A patient with prostate cancer has developed a pathological compression fracture of the L4 vertebral body due to metastatic involvement. The patient complains of severe lower- back pain, especially during movement.

Assess the pain intensity using the VAS.

Case 3

Patient K., 63 years old, underwent abdominoperineal excision of the rectum for cancer T4N1M0. Two years later, severe sacral pain gradually developed, radiating to the lower limbs, accompanied by urinary disturbances. One week ago, the pain intensified sharply, and walking became impossible. X- ray examination revealed metastatic destruction of the sacral bone with a pathological fracture. A full course of palliative radiotherapy to the sacral region was administered (total dose 72 Gy), resulting in temporary pain relief. However, after 3 months the pain intensified again, accompanied by autonomic disturbances, cardiac dysfunction, and urinary retention. The patient was hospitalised. A permanent urinary catheter was inserted.

Choose the most appropriate method of pain relief in this case.

Case 4

In a terminally ill incurable oncology patient, physical and emotional suffering has become unbearable and unresponsive to correction.

What should be the doctor’s further approach?

Case 5

A patient with Pancoast tumour has developed extremely severe pain in the left shoulder girdle, radiating to the heart area, head, and arm. The patient has never experienced such intense pain. The pain is accompanied by autonomic disturbances and is regarded by physicians as causalgia.

Assess the pain intensity using the VAS.

Case 6

A patient with gastric cancer and spinal metastases has developed a pathological compression fracture of the Th11 vertebral body.

Which type of palliative therapy is appropriate in this case?

Case 7

A patient with breast cancer has developed lymphoedema of the upper limb, accompanied by moderate pain.

What VAS score corresponds to this level of pain?

Case 8

In a bedridden incurable oncology patient, tissue induration and blister formation are observed in the sacral area, but without visible epidermal damage.

Which stage of pressure ulcer development does this correspond to?

Answers to the situational tasks

1. Semi- sitting position, expectoration into a tray, intensive haemostatic therapy, transfusion of blood components.

2. 3 points on the VAS.

3. Catheterisation of the epidural space with continuous administration of local anaesthetics.

4. Inducing a medically controlled sedative state without depriving the patient of life.

5. 4 points on the VAS.

6. Palliative radiotherapy in combination with bisphosphonates.

7. 2 points on the VAS.

8. Stage 1 pressure ulcer.

Appendix 1

DIRE Assessment: Selecting Patients for Long- Term Opioid Analgesia

The DIRE assessment is a clinical rating tool used to predict the suitability of a patient for long- term opioid analgesia in the management of chronic non- cancer pain. It consists of four factors that are evaluated separately and then summed to produce the DIRE score: Diagnosis, Intractability, Risk, and Efficacy.

The Risk factor is divided into four subcategories, each of which is scored independently; the scores are then added together. The risk subcategories are: psychological health, chemical health, reliability, and social support.

Each factor is scored on a scale from 1 to 3, where:

1 represents the least convincing or least favourable case for prescribing opioids,

3 represents the most convincing or favourable case for prescribing opioids.

The total score is used to determine whether the patient is an appropriate candidate for opioid analgesia. Scores may range from 7 points (the lowest possible score, if the patient receives all 1s) to 21 points (the highest possible score, if the patient receives all 3s).

In reliability and validity studies, higher scores (14 or above) indicate a more successful prescribing process in terms of patient compliance and treatment effectiveness.

For each factor, the patient's score from 1 to 3 is based on the explanations provided in the right- hand column.

Table 1

DIRE Assessment - Selecting Patients for Long- Term Opioid Analgesia [11]

Score	Factor	Explanation
	Diagnosis (D)	1 = A benign chronic condition with minimal objective findings, or no clear diagnosis. Examples: fibromyalgia, migraines, non- specific low back pain. 2 = A slowly progressive condition with moderate pain, or a stable condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain.

Score	Factor	Explanation
		3 = An advanced condition associated with severe pain and clear objective findings. Examples: severe ischaemic vascular disease, advanced neuropathy, severe spinal canal stenosis.
	Intractability (I)	1 = Several treatment methods have been tried, and the patient plays a passive role in the pain- management process. 2 = Most standard treatments have been attempted, but the patient is not fully engaged in the pain- management process, or barriers prevent full participation (e.g., insurance issues, transportation problems, medical comorbidities). 3 = The patient is fully engaged in an appropriate range of treatments, but the response has been inadequate.
	Risk (R)	**Calculate the total score: I + CH + D + SS**
	Psychological (P)	1 = Serious personality dysfunction or a mental illness that interferes with treatment. Examples: personality disorder, severe affective disorders, significant personality problems. 2 = Personality or mental- health issues that moderately interfere with treatment. Examples: depression or anxiety- related disorders. 3 = Good therapeutic rapport. No significant personality dysfunction or mental illness.
	Chemical Health (CH)	1 = Active or very recent use of illicit substances, alcohol abuse, or misuse of prescribed medications. 2 = Use of chemical coping strategies (using medications to manage stress) or a history of chemical dependency currently in remission. 3 = No history of chemical dependency. No preoccupation with drugs or chemical coping.
	Reliability (R)	1 = Serious personality dysfunction or a mental illness that interferes with treatment. Examples: personality disorder, severe affective disorders, significant personality problems. 2 = Personality or mental- health issues that moderately interfere with treatment.

Score	Factor	Explanation
		Examples: depression or anxiety- related disorders. 3 = Good therapeutic rapport. No significant personality dysfunction or mental illness.
	Social Support (SS)	1 = Life is chaotic. Minimal support from family or close relatives. Loss of most normal life roles. 2 = Some reduction in social connections and life roles. 3 = Supportive relationships with family/close relatives. Engagement in work or school and no social isolation.
	Efficacy (E)	1 = Poor functioning or minimal pain relief despite moderate- to- high opioid doses. 2 = Moderate benefit with some improvement in functioning in several areas (or insufficient information - opioids have not yet been tried, or doses have been very low, or the trial period has been too short). 3 = Good pain relief, improved functioning, and enhanced quality of life with stable doses over a long period.

Total score D + I + R + E = _____

Scores 7–13: Not an appropriate candidate for long- term opioid analgesia.

Scores 14–21: May be an appropriate candidate for long- term opioid analgesia.

Appendix 2

Non- opioid analgesics commonly used for the treatment of chronic pain [3]

International name	Single dose, mg	Dosing interval, hours	Maximum daily dose, mg	Half- life, hours
Acetylsalicylic acid (Aspirin)	500-1000	4-6	3000	0,25
Paracetamol (Acetaminophen)	500-1000	4-6	4000	2-3
Ibuprofen	200-400	4-6	1200	2-2,5
Ketoprofen	25-50	6-8	300	1,5-2
Indometacin (Indomethacin)	25-50	8-12	200*	4-9
Ketorolac***	10-30	6-8	90**	5-6
Mefenamic acid	250-500	6-8	1500	3
Diclofenac	50	8	150	2
Metamizole sodium (Dipyrone)***	500-1000	8-12	3000	-

Notes:

** — for long- term treatment, 75 mg.*

*** — in older adults and in individuals weighing less than 50 kg — not more than 60 mg.*

**** — not recommended for long- term treatment due to myelotoxicity.*

Appendix 3

Equianalgesic opioid doses [1]

Medicinal products	Dosage form	Dose* mg/d				
Tramadol	tablets, ampoules, suppositories, drops	400				
Tramadol (12- hour prolonged- release)	tablets	400				
Omnopon	ampoules	60	60-100	100-160		
Buprenorphine	tablets	1,6	1,6-2,8	2,8-3,6		
Buprenorphine	ampoules	1,2	1,2-2,1	2,1-3,0	3,0-3,6	
Morphine hydrochloride	ampoules	40	40-70	70-100	100-120	

Notes:

* — the daily dose may be increased based on individual clinical indications.

— the therapeutic potential of the medicine has been exhausted; it is advisable to use analgesics with a more pronounced analgesic effect.

Appendix 4

Pharmacological treatment of chronic pain [3]

Medicinal products	**Standard initial adult doses**	**Notes**
	Mild pain	
Non- opioid analgesics	Acetylsalicylic acid Standard initial adult doses 650 mg orally every 4 hours, or 1000 mg orally every 6 hours after food	Discontinue if dyspepsia or tarry (melena- like) stools occur. Do not administer to children under 12 years of age. Do not administer in stages III and IV of HIV infection.
	Paracetamol Standard initial adult doses: Two 500 mg tablets orally every 4–6 hours after food.	Maximum 4 g per day
	Ibuprofen Standard initial adult doses: 400 mg every 6 hours; the first dose on an empty stomach, subsequent doses after food.	
	Ketoprofen 50–100 mg orally, or Ketorolac 10–30 mg orally.	Maximum daily doses: Ketoprofen - 200 mg; Ketorolac - 60 mg.
	Mild or Moderate pain	
Non- opioid analgesics	Acetylsalicylic acid Standard initial adult doses 650 mg orally every 4 hours, or 1000 mg orally every 6 hours after food.	Discontinue if dyspepsia or tarry (melena- like) stools occur. Do not administer to children under 12 years of age. Do not administer in stages III and IV of HIV infection.
	Paracetamol Standard initial adult doses: Two 500 mg tablets orally every 4–6 hours after food.	Maximum 4 g per day.
	Metamizole Standard initial adult doses: Single dose: 0.5–1.0 g orally. Maximum daily dose: 6 g.	Indications: tumour- related pain, colicky pain, or chronic pain.
	Ketoprofen 50–100 mg orally or Ketorolac 10–30 mg orally Standard initial adult doses:	Maximum daily doses: Ketoprofen — 200 mg; Ketorolac — 60 mg.

	Ketoprofen 50–100 mg orally, or Ketorolac 10–30 mg orally.	
Non- opioid analgesics	Tramadol prolonged- release Standard initial adult doses: 100–200 mg orally every 8–12 hours.	Maximum 600 mg per day.
Moderate or Severe pain		
Non- opioid analgesics	Acetylsalicylic acid Dose: 650 mg orally every 4 hours, or 1000 mg orally every 6 hours after food.	Discontinue if dyspepsia or tarry (melena- like) stools occur. Do not administer to children under 12 years of age. Do not administer in stages III and IV of HIV infection.
	Paracetamol Dose: Two 500 mg tablets orally every 4–6 hours after food.	Maximum 4 g per day
	Ketoprofen 50–100 mg orally or Ketorolac 10–30 mg orally Dose: Ketoprofen 50–100 mg orally, or Ketorolac 10–30 mg orally.	Maximum daily doses: Ketoprofen — 200 mg; Ketorolac — 60 mg.
Opioid analgesics	Tramadol prolonged- release Dose: 100–200 mg orally every 8–12 hours.	Maximum 600 mg per day.
	Buprenorphine (sublingual tablets) Dose: 0.2 mg sublingually. Notes: Maximum daily dose 3.0 mg. Adverse effects are less pronounced than with morphine. If effective and well tolerated, it may be used for months. Morphine (Promedol, Omnopon) Dose: for oral administration: 2.5–5 mg every 4 hours. If no oral formulation is available, the injectable solution (5 mg in 5 ml ampoules or 50 mg in 5 ml ampoules) may be used by placing drops into the mouth or administering rectally with a syringe (without a needle). If pain persists after 24 hours, the dose may be increased by 1.5–2 times.	The dose depends on pain intensity; there is no strict maximum daily dose, but respiratory rate must be monitored. Temporarily discontinue the medicine if the respiratory rate falls below 8 breaths per minute. Laxatives should be prescribed during opioid therapy.
Treatment of different pain types		

Neuropathic pain (burning, shooting, tingling sensations, post- herpetic neuralgia, etc.)	Amitriptyline Dose: 25 mg orally at night, or 12.5 mg orally twice daily.	If necessary, gradually increase the dose to 50 mg at night or 25 mg twice daily.
Muscle spasms	Diazepam Dose: 5–10 mg orally 1–2 times per day.	
Terminal stages of disease managed at home, and the following conditions: • Oedema around a tumour • Severe candidal oesophagitis with ulceration and impaired swallowing Nerve compression Persistent headache due to intracranial hypertension Persistent headache due to intracranial hypotension	Dexamethasone. Dose: 2–6 mg per day orally after food or Prednisolone. Dose: 15–40 mg per day orally after food for 7 days. Clonidine. Dose: 0.075 mg orally 3–4 times per day after food, in combination with other non- opioid and opioid analgesics. Butorphanol. Dose: 4–6 mg per day in combination with non- opioid analgesics. Note: Opioid agonist–antagonist; do not combine with opioid analgesics and do not use in active injecting drug users due to the risk of precipitating withdrawal syndrome (rise in blood pressure in both the major and especially the minor circulatory systems).	Glucocorticoids improve the condition of patients in terminal stages of disease: appetite and general well- being may improve. Reduce the dose as much as possible. Discontinue if the patient's condition does not improve within 3 weeks of treatment.
Herpes zoster	At the first appearance of the rash: Valaciclovir 1 g PO every 8 hours for 5–7 days. Acute pain: Metamizole, Tramadol prolonged- release 100-200 mg PO every 8-12 hours, maximum 600 mg per day. Post- herpetic neuralgia: Amitriptyline, Low dose: 12.5–25 mg orally at night, or 12.5 mg orally twice daily, or Gabapentin with gradual dose escalation up to 2400 mg per day orally.	
Colicky abdominal pain	Drotaverine (No- Spa) 40–80 mg orally 4–6 times per day after food. Metamizole or	

	Hyoscine butylbromide 10–20 mg orally 3–5 times per day.	

Notes::

** Several analgesics from the same pharmacological group should not be prescribed together for a single dose; aspirin taken every 4 hours may be alternated with paracetamol taken every 4 hours, so that the two medicines alternate every 2 hours.*

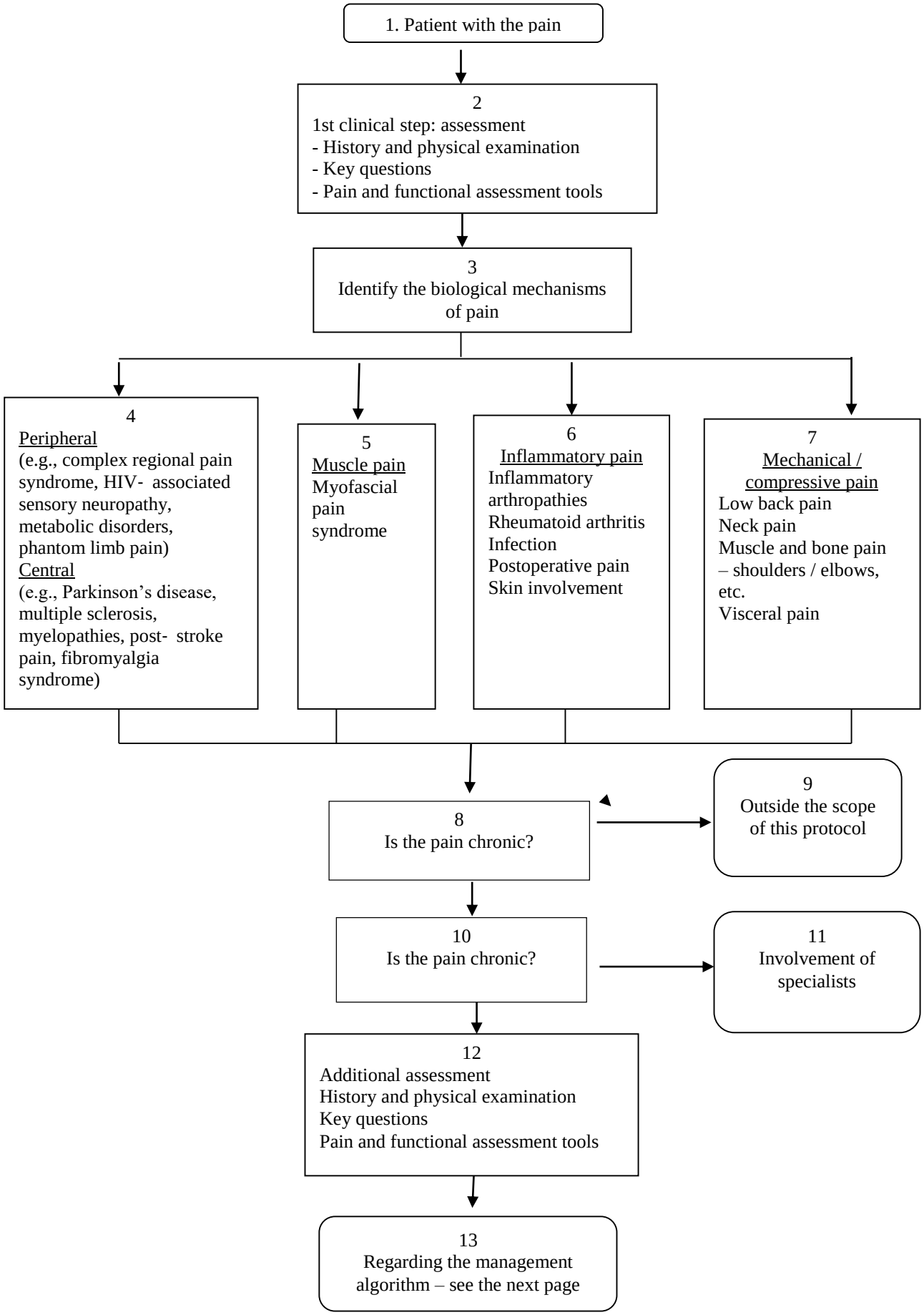
*** After the pain syndrome has been controlled, if the patient has been taking opioids for fewer than 7 days, opioid analgesics may be discontinued immediately or the dose may be reduced over 24 hours. If opioid (morphine) therapy has lasted 7 days or longer at a daily dose of 40 mg or more, the dose should be reduced according to a tapering schedule.*

Morphine dose- reduction schedule	Interval between opioid administrations (hours)							
	6	10	12	12	24 at night	24 at night	36 at night	36 at night
Single doses used for stepwise dose reduction (mg)	5	5	5	2,5	2,5	2,5	2,5	2,5

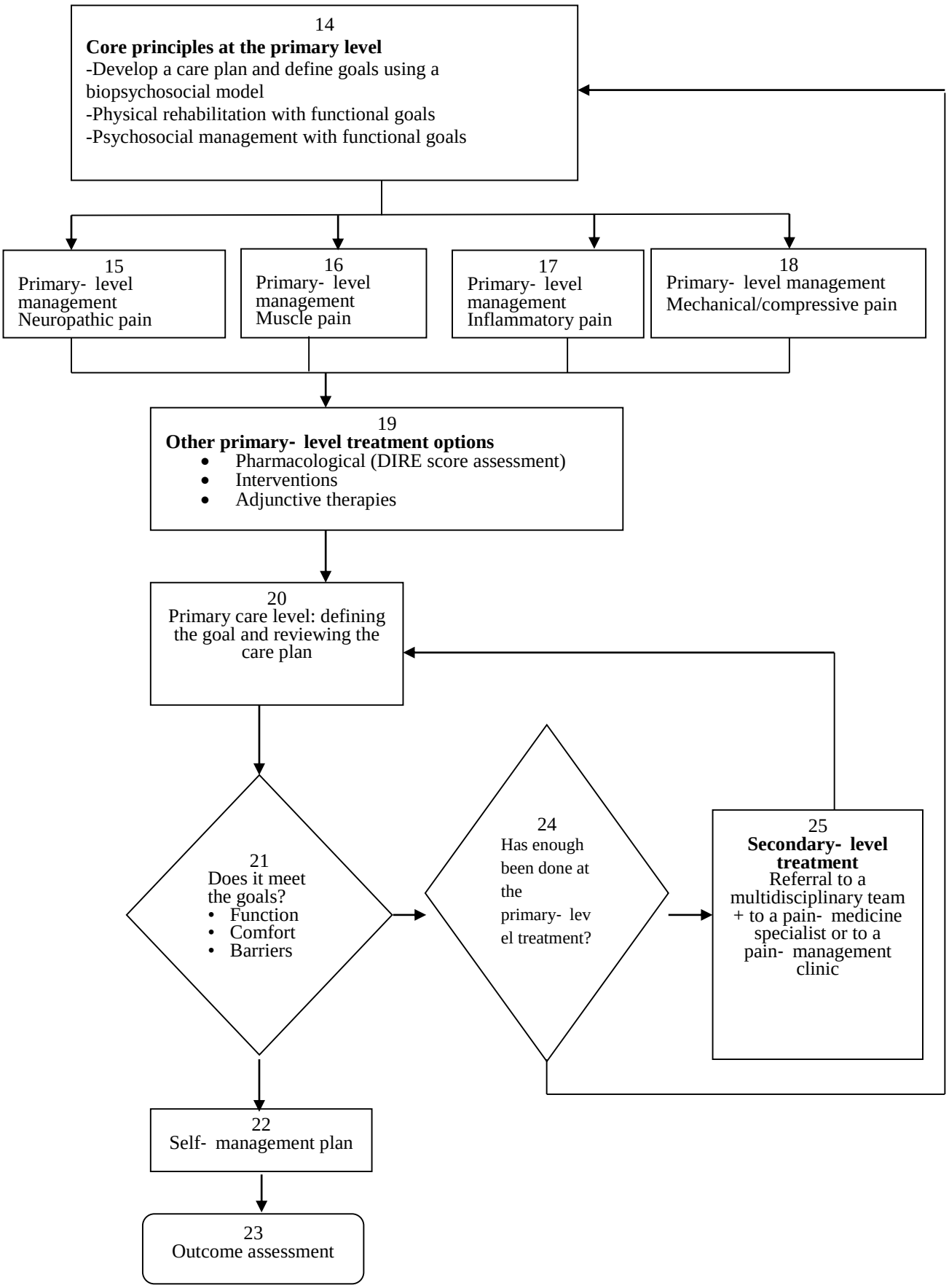
It is advisable to continue placebo therapy for a further 3–5 days.

Appendix 5

Algorithm for the assessment and management of chronic pain [5]



Appendix 5
(continuation of the scheme)



Appendix 6

Management of side effects of opioid analgesics [2]

Side effect	Recommendations
Constipation .	•Increase fluid and fibre intake in the diet. •During opioid therapy, consider a laxative that increases stool bulk (for example, Lactulose 10 ml PO TID or Laminarid 5-10 g 1-2 teaspoons after meal), and, if needed, an agent that stimulates bowel motility (Izaphenin 10 mg PO after meal BID or 20 mg at the bedtime). Bisacodyl 5-15 mg PO in 30 min before meals or in bedtime, or 10-20 mg rectal suppositories). Sennosides A + B 10-30 mg PO after meal in the bedtime, typically in the evening. •Implement constipation prevention measures (if the patient does not have chronic diarrhoea).
Nausea and vomiting	Consider an antiemetic. Nausea and vomiting usually subside within a day
Respiratory depression (if Morphine is taken PO with gradually increased dose)	• Use methods that stimulate breathing. • If respiratory depression is pronounced, omit the next dose and then reduce subsequent doses. • In patients with severe pain in a terminal condition, some degree of respiratory depression may be acceptable.
Confusion or drowsiness (not caused by other factors)	• These effects typically occur at the start of treatment or after dose increases and often resolve within a few days. They may also occur in terminal renal failure. • Reduce the dose or increase the interval between doses..
Itching or myoclonus (marked muscle twitching during observation)	• If the patient is receiving a high dose, consider reducing the dose, switching to an alternative regimen, or using a different opioid. • Reassess the patient, as morphine may be ineffective in certain conditions and other treatments may be required..
Excessive sleepiness	• Prolonged sleep may reflect CNS exhaustion and a need for rest. • If this state persists for more than two consecutive days, consider reducing the dose

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