Palliative Care for Non-malignant Patients

Dr. Lam Po Tin, Senior Medical Officer, United Christian Hospital

E mail: ptlam9262@yahoo.com

Case 1

Madam Lee was a 78 years old lady who suffered from diabetes mellitus, hypertension, ischaemic heart disease, gout, and had been diagnosed end stage renal disease by renal physician since January 2004 with mutual decision on conservative therapy (i.e. not for renal replacement therapy). She was admitted to acute geriatric ward in September 2004 for fluid retention causing generalized edema including acute pulmonary edema. Palliative care physician was asked for advice on symptom control. Her symptoms were mainly nausea and dyspnoea which were satisfactory controlled with oral haloperidol and lasix infusion. She then developed symptoms and signs of uraemic encephalopathy and was controlled with subcutaneous midazolam and she passed away peacefully few days later.

Case 2

Madam Wong was a 72 years old lady who suffered from hypertension, atrial fibrillation, diabetes mellitus, ischaemic heart disease, and congestive heart failure (New York Heart Association Classification IV) and was under the care of cardiologist. In 2002, although she was inserted an Implantable Cardioverter Defibrillator (ICD) for ventricular arrhythmia, biventricular pacing for heart failure was attempted with failure. She had multiple hospital admissions since then. During her last admission in Dec 2003, palliative care physician was consulted for symptom control. Her main symptoms were easy fatigue, dyspnoea at rest with orthopnoea and insomnia. Low dose morphine was tried with no effect. Benzodiazepine was prescribed with modest improvement in sleep and dyspnoea condition. She died suddenly at home one month later.

Discussion

The hospice movement was initially developed in response to the perceived need of terminally ill cancer patients. However, the emergence of AIDS/HIV in the 1980s presented a major challenge to palliative care, and increasingly, more people in the developed world die from chronic diseases other than cancer. Hence, palliative care should not only be considered as part of cancer care, but also throughout medical care.

Data collected by the United Kingdom (UK) National Council for Hospice and Specialist Palliative Care Services showed that over the last 4 years (1999 – 2003), the number of in-patients with non-malignant conditions had varied somewhat from 4.4 to 5.4% among all palliative care units in UK. There is, also, anecdotal evidence that increasing numbers of patients with non-malignant disease are now being referred to palliative care services in some parts of UK.

In Hong Kong, we do not have any local data on this issue. The impression is that only a few non-malignant terminally ill patients are directly receiving care from palliative care services, although the un-met needs are perceived high. The reasons for this are complex. The prognostic uncertainties, a lack of relevant expertise, fear of “flooding” of caselode, boundary dispute between professionals and between services, and issue on funding and human resources may all contribute.