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PALLIATIVE CARE IN AIDS CASES

Carmen Manciuc, Cristina Nicolau, J. L. Prisacaru, Carmen Dorobăț

The Infectious Diseases Clinic of Iași, HIV/AIDS Department

Abstract. Introduction. Terminal stages of AIDS must benefit from special attention and care for both patients and their relatives. **Objectives**. Establishing a team and protocols of palliative care for these patients. **Material and method**. The retrospective study of case report forms of patients who died of AIDS in the Infectious Diseases Clinic of Iași. In the department of HIV-infected patients of the Infectious Diseases Hospital of Iași, within an interval of 3 years (2007-2009), there were 28 deaths, with an average of 9 patients per year. Most of them died of multiple organ failure, in the final stage of AIDS (10 cases), meningeal coma (5 cases) or respiratory failure during the terminal pulmonary pneumocystosis TB (13 cases). The palliative therapy was conducted throughout the hospitalisation of the terminal stage. The patients who survived longer required psychological support from admission until they lost their state of consciousness - they were 23 in number, with a duration of psychological palliation from 2 to 32 days. **Conclusions**. Palliative care, in cases of terminal AIDS disease, must be conducted by a team including specialists in infectious diseases, intensive care, psychologists and it also addresses the patients' families.
Keywords: HIV/AIDS, palliative care, terminal stage.

Introduction

The international community is turning increasingly more att ention to suffering people, in end stages of various chronic diseases (cancer, neurological diseases, AIDS) to facilitate and give the due dignity to each and every person crossing into nothingness.

In the case of an illness caused by the infection with HIV, we must acknowledge and appreciate the efforts of the international community, physicians, pharmacists, scientists involved in the pharmaceutical industry, to discover the pharmacological agents that have changed the history of the disease. Thus, a disease which initially had a life expectancy of approximately 3 months has become a chronic disease with a life expectancy of up to 20 years.

Carmen Doina Manciuc
2, Octav Botez, Iași, Romania
E-mail: dmanciuc@yahoo.com

The real possibility of suppressing viral replication through various mechanisms - the use of nucleoside and non-nucleoside reverse transcriptase inhibitors, of protease and integrase inhibitors, of fusion inhibitors - are the weapons that the clinician has at hand in Romania, as elsewhere in civilised countries.

Special psychological profile

In general, the psychological profile of a patient with a chronic illness is a special one, and in the context of HIV-infected patients in our country, the problem is even more complicated as they have a special profile - most of them were diagnosed in childhood and have developed their personality and tried to integrate psycho-emotionally in society under this great burden, the chronic disease.

The phenomenon of stigmatisation and marginalisation is not infrequently encountered. It is therefore appropriate to have a new approach to the infected patients, the more as they become adults, they want to live a normal life, to form a family and have children.

The doctor and his/her team

The doctor is no longer alone with the patients, but interacts with them in a team, together with psychologists and social workers. Working in such groups during psychologically supported meetings, have led the patients to the full awareness of their problems, to understanding and overcoming them.

Not rarely have we seen touching moments of human solidarity on the part of the community of infected patients assisted in our department, when one of them was in the terminal phase. And if they can do this, if they can support one another we, those who take care of them, along with policy makers, can certainly do much more for them.

In the psychological support, which we want to be strong, we must not neglect the support we need to give to their families in overcoming the difficult moments and preventing the mourning neurosis.

Experience of our department

In the department of HIV-infected patients in the Infectious Diseases Hospital of Iași, within a time span of 3 years (2007-2009) there were 28 deaths, with an average of 9 patients per year. Most of them died of multiple organ failure, in the final stage of AIDS (10 cases), meningeal coma (5 cases) or respiratory failure during the terminal pulmonary pneumocystosis TB (13 cases).

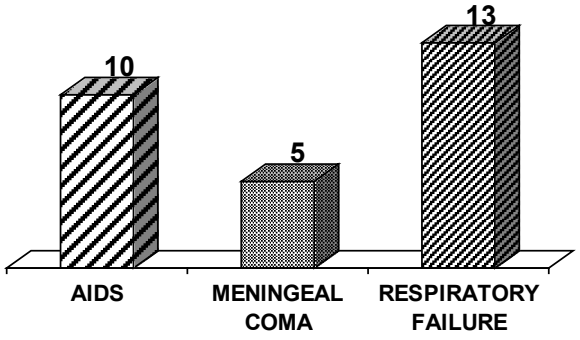

Figure1. Causes of death – HIV patients 2007 – 2009

The palliative therapy was conducted throughout the hospitalisation of the terminal stage. The patients who survived a longer time required psychological support from admission until they lost their state of consciousness - they were 23 in number, with a duration of psychological palliation from 2 to 32 days.

The team was made up of: the family doctor, a psychologist, a nurse, and care staff. Out of the total number of patients, 19 were aged 17-20 and only 2 were over 50, with an average of 10.5 days of hospitalisation, with extremes between 2 days and 34 days.

Terminal-stage patients were isolated from other patients hospitalised at the time. The care provided

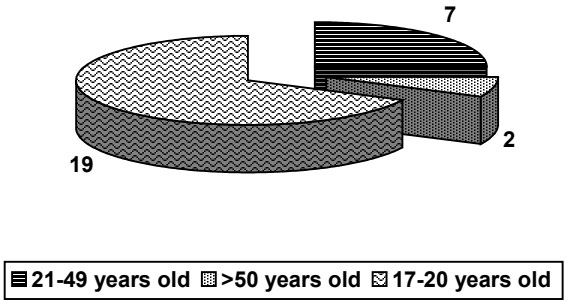

Figure1. Deaths – age groups

the daily cleaning of the patient, or whenever needed, ensuring of fluid and caloric intake, preventing fever and cerebral edema and not least, soothing the pain and providing the optimal oxygen flow. The therapy consisted in the administration, sometimes through the nasogastric tube, IV on one to two venous lines, of etiotropic, physiopathogenic and substitution therapy. The psychological support of the family was a point that we followed throughout the terminal stage of patients, with their programming and subsequent meetings and psychological checks, to which, we have to admit, the adherence was relatively low.

Conclusions

Future trends are improving the working methodology of the team; joining the palliative HIV/AIDS program, which we wish to develop on national level; an ethical approach to these patients; the achievement of a proper medical and psychological management according to a recognized and adapted methodology.

Palliative care remains a challenge for health professionals, for each of us, if we want to ensure the minimisation of physical and mental suffering of all those involved, with maintaining the dignity and respect for the patient infected with HIV.

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