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PALLIATIVE CARE IN HIV - FROM THEORY TO PRACTICE REFLECTIONS ON A CASE PRESENTATION

Cristina Nicolau, Carmen Manciuc, J. L. Prisacaru, Alexandra Largu, A. Vâță, Carmen Dorobăț

The Infectious Diseases Clinic of Iaşi, HIV/AIDS Department

Abstract. Introduction: Palliative care associates a wide range of therapies designed to ensure the improvement of the quality of life of HIV seropositive patients. Objectives: To underline the importance of medical and non-medical palliative care measures (with multidisciplinary implications) in the treatment of the HIV infected patient. Material and method: The evolution of an HIV seropositive patient was analyzed, from the time of detection (2005) until 2009, dynamically following the clinical - immunological and psychological curve. Initial denial of the diagnosis (which caused the late arrival in our department) marked the further progress of the case. The patient required a prolonged period of hospitalization (45 days) and sustained medical support, which involved a multidisciplinary team, joined with psychological counseling with the aid of the family, various health professionals and representatives of the church. Conclusions: establishing a partnership relationship between doctor and patient by integrating concepts, principles and practical rules of palliative care in HIV are important in the approach the HIV infected patient.
Keywords: principles, HIV, multidisciplinary, partnership, palliative

Palliative care - Brief History

Palliative care (PC) associates a wide range of therapies that seek to ensure a better quality of life for both patients suffering from incurable illnesses and their families, based on the principle that „every individual has the right to die dignified", an inalienable and essential human right.

In the PC development there are four acknowledged stages:

Stage 1: 1967 - following the British model, the first district hospitals to care for patients diagnosed with cancer appear.

Stage 2: 1975 - the palliative care unit of the Queen Victoria Hospital in Montreal, becomes a starting point for the units to be later created in Europe.

These two stages had a local individual character, not being part of the government's concerns of the time.

Stage 3: 1980 - the palliative care of people suffering from cancer became an integral part and was acknowledged as part of the public health system, which marks another step in the PC evolution.

Stage 4: 1990 - the term 'palliative care of HIV" appears customised as such.

In Europe, the implementation of palliative strategies was as follows: Italy - 1981, Norway 1984, Poland 1984, France - August 26, 1987, Belgium - 1990 Switzerland - 1990; Germany - palliative home care. [1]

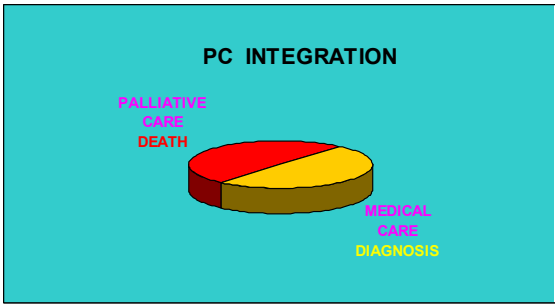

Figure 1. PC integration

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

Hospital Palliative care vs Home Palliative care

PC needs are estimated at approximately 30% of HIV infected patients.

There is a paradox between the desire of patients to die at home and institutional reality, as found in the proportion of deaths from HIV/AIDS: 70% in hospitals, 30% at home. 69% of the people who need palliative care can be found in hospitals. It is the „privileged place" for the dispensarisation where the concept of „humanitarian medicine" is the most illustrative and the environment with highest death rates. [2]

Palliative hospital care involves a multidisciplinary team: physicians (34% oncologists, 20% specialists in palliation, 17% anesthesiologists, psychiatrists 3%), nurses, social workers, psychologists, physiotherapists and representatives of the church. [3]

Home PC is carried out by the general practitioner who takes care of approximately 31% of the people who need palliative care.[4]

Types of palliative care

PC involves a number of health care procedures such as pain control, treatment of nausea, fatigue as well as non-medical care such as psychological support, spiritual support and help to prepare for death, patient peer support.Basically, palliative treatment consists in the treatment of acute episodes and also the control of chronic symptoms.

Health care

Health care involves the treatment of acute or chronic symptoms. According to a study conducted in France [5], the prevalence of symptoms in the HIV/AIDS patient is as follows (table I):

Symptom	Symptoms prevalence in the HIV/AIDS patient
Pain	52%
Asthenia	50%
Anxiety	40%
Sadness	32 %
Weight loss	31%
Nausea	28%
Depression	24%

Tabel I. Symptoms prevalence HIV/AIDS patient

Pain therapy and analgesic principles

The centerline of PC is the fight against pain. 70% of the patients recognize this symptom which affects the quality of life in a high percentage (76% of cases). As principles of analgesic use specialists acknowledge the following: administration at regular intervals, adapted to pain levels, as much as possible given orally, in individualized dosage and only according to analgesic levels.

Non-medical care - psychological support

Telling the patient about the diagnosis involves a number of attitudes that concern the patient (does the absence of additional questions mean that the patient is satisfied with the explanations?), the family (the anxiety to face the fatal diagnosis, the fear of confronting the emotions of a patient who is difficult to manage), the doctor (in 2002 the concept of „shared secret" appears - the family can be informed about a serious prognosis, thus protecting the patient).

Support groups such as family, friends or church (spiritual accompaniment) play an important role. Non-medical psychological care involves relaxation techniques, cognitive restructuring, stress management, the cognitive-behavioral therapy being indicated whenever behavioral manifestations are excessive in relation to the somatic plan.[6,7]

From theory to practice

The patient, female, aged 27, coming from a rural area, was detected HIV positive in 2005, when conducting an epidemiological survey (her husband died the same year of AIDS and pulmonary TB). At the time of detection she was stadialized in A1 HIV stage.

The unannounced change of residence and the missed recommended periodical checks caused the loss of the patient from the Iaşi Regional Center patient records, for the following five years (2005-2009).

In August 2009 she was fortuitously hospitalized (acute enterocolitis) in the municipal hospital she belonged to and from where she was then transferred to our department.

On admission: afebrile, influenced general condition, cachexia, dry skin, marked pallor, massive oropharyngeal candidiasis, tachycardia (CF = 130/min), hypotension (BP = 85/40 mmHg), hepatomegaly to 4 cm below the costal margin, with hard consistency, oliguria, speeded intestinal transit (7 semiconsistent stools/day, for about 2 months).

Paraclinical explorations: CD4 = 68/cmm, VL = 2.190.000 cp/ml, Hb = 5.1 g%, WBC = 440/cmm, Thr = 10.000/cmm, urea = 102 mg%, creatinine = 2.8 mg%; RA = 6 mEq/L, Na = 118 mEq /L, K = 0.89 mEq/L, Cl = 117 mEq/L, CD/CS = negative, pharyngeal exudate-present *C. albicans*.

Stage diagnosis: C3 stage AIDS disease; Waisting syndrome; Pancytopenia; Oropharyngeal candidiasis; Acute renal failure, with tubular potasium loss; Chronic diarrhea; Secundary dehydration syndrome.

In development: paroxysmal rhythm disorder due to hypokalemia impairment appeared (0.89) - cardiovascular stroke revived (Cardiology Department), acute renal failure - 5 days of hemodialysis (Nephrology Department) - resumption of diuresis, right buttock abscess - incision + drainage (surgical department).

Medical treatment involved a multidisciplinary team formed of an infectionist, a cardiologist, a nephrologist, a surgeon. They recommended broad spectrum antibiotic therapy, transfusion with isogroup red blood cells, leuko-platelet concentrate, plasma, ivp, hydroelectrolytic, acid-base and volemic support rebalancing, oral + parenteral rehydration, iv antifungals (fluconazole injection), ARV medication (SQV/RTV + ABC+3TC).

Non-medical treatment: the essential role was played by the psychologist, by helping the patient to accept the diagnosis and then to obtain permission to inform her new family (the epidemiological survey identified the new husband of the patient as HIV seropositive)

This involved the collaboration with:

- The rest of her family - a collaboration of real help;
- The church - the patient asked several times to talk with a representative of the church for confession;
- The patient - long term - currently aware of the severity of the disease and the need for monitoring and regular dispensarisation.

The clinical and biological evolution was slowly favorable but with prolonged hospitalisation (45 days).

Currently, the patient has returned home, is in a satisfactory general condition. Biological constants are within normal limits (only a slight anemia - Hb = 10.3 g% persists). Immunologically: CD4 = 142/cmm, VL = 9417 cp/ml, adherent to ART, cooperative.

Conclusions

Palliative care tends to play an increasingly important role in HIV/AIDS in Romania. Palliative care requires a long-term interdisciplinary collaboration. The doctor - patient relationship becomes a partnership in fighting the disease. The need to integrate concepts, principles and practical rules for palliative HIV care in the public health system in Romania is a must.

References

1. WHO, 2005. Patient Self Management and Caregiver Booklet: HIV care, symptom management and end of life care. June 2005 draft. **WHO: Geneva.**

2. WHO, 2004. Chronic HIV Care with ARV Therapy. WHO: Integrated Management of Adolescent and Adult Illness (IMAI) **Modules for HIV Care.**

3. WHO, 2004. Facilitator Guide for WHO ART Aid Training Course. WHO: Integrated Management of Adolescent and Adult Illness (IMAI) **Modules for HIV Care.**

4. Stajduhar KI, Davies B. Palliative care at home: reflections on HIV/AIDS family caregiving experiences. *J Palliat Care.* **1998;14(2):14-22.**

5. Fontaine A, Larue F, Lassaunière JM. Physicians' Recognition of the Symptoms Experienced by HIV Patients: How Reliable? *The Journal of Pain and Symptom Management* **1999;18,4:263-270.**

6. Selwyn, P, Forstein M. 2004. Overcoming the False Dichotomy of Curative vs Palliative Care for Late-Stage HIV/AIDS.

7. Carmen Manciuc, Cristina Nicolau, Janny Liviu Prisacaru, Carmen Dorobăț. Palliative care in aids cases.*Therapeutics, Pharmacology and Clinical Toxicology* **2010; 4: 300-301.**