Regional Palliative Care Services

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Ascites Management in the Palliative Setting

By Seth Gysbers, Palliative Care Nurse Consultant

Ascites

Ascites, which is an accumulation of fluid in the peritoneal space, is a common part of many life limiting conditions near a person's end of life. It can be uncomfortable as it stretches skin and in severe cases can displace or put pressure on the bowel and other internal structures. Pain in the abdominal region or the impact on someone's breathing from ascites limiting the ability of the lungs to fully expand, can lead to much distress. Therefore, early identification and prompt treatment of ascites is important. This article will review the major causes of ascites and discuss a palliative approach to the management of ascites.

What causes ascites and what does it mean?

According to Downing (2008), the most common causes of ascites at end of life are cirrhosis (80%) and malignancy (10%). The other 10% of cases are caused by heart failure, renal failure, tuberculosis, pancreatic and other miscellaneous issues (i.e. cachexia, obstruction of lymph tissue by tumours, or increased portal vein pressure). Ascites is often indicative of a limited life expectancy, in the nature of weeks to months, especially if the cause of the ascites is irreversible or untreatable (Pereira, 2008).

I think my patient has ascites, what do I do?

The first step of managing any symptom is to perform a comprehensive assessment, as per Northern Health's Palliative Care Symptom Guidelines (2008). This may include a review of the client's chart, interview of the client/family using the O-V symptom assessment acronym and performing a physical assessment. Also, re-

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member to review the client's current medications and any recent investigations.

Initial signs and symptoms of ascites may include abdominal pain, anorexia, dyspnea/orthopnea, abdominal distension, peripheral edema, shifting dullness on percussion, esophagitis, gastric reflux or emesis (NHPC Symptom Guidelines, 2008).

Diagnostic tests may also be indicated to determine cause and or treatability. However, before performing any investigation consider the client's goals-of-care, disease burden/trajectory and functional status. Is what you are proposing likely to cause more harm than benefit? If the answer is no, and the information you have from your assessment indicates there may be a reversible cause investigations may be appropriate. Investigations to consider may include an ultrasound or abdominal CT to assess the location of the fluid and the volume of fluid present. A paracentesis can provide you with more specific information about the nature of the accumulated fluid and may guide treatments (NHPC Symptom Guidelines, 2008).

Management:

In palliative care, the goal of ascites management is relief of distressing symptoms. NHA's Palliative Care Guidelines (2008), provide the following recommendations. In minor cases of ascites where a client is asymptomatic monitoring (abdominal girth measurements weekly and daily weights) may be sufficient. If monitoring abdominal girth ensure you are measuring at the same place. Cases of symptomatic minor to moderate ascites generally require treatment with diuretics and dietary salt restriction. These interventions tend to work best in clients with ascites due to congestive heart failure, cirrhosis, and numerous liver metastases. This type of ascites typically tends to be transudative (low in albumin and a clearer fluid). Initially Spironolactone 100mg day is recommended. Titrate Spironolactone to 400 mg daily if needed. Furosemide 40 mg daily, titrated slowly up to 120 mg daily, may be added to increase diuresis and reduce the risk/incidence of hyperkalemia. The goal is daily weight loss of 0.5-1kg per day until symptoms are relieved.

In severe cases of ascites caused by peritoneal carcinomatosis or where lymph obstructing tumours are present, paracentesis is recommended to provide rapid (sometimes temporary) relief of symptoms. Diuretics and salt restriction may still play some role in these situations; however, these measures by themselves are usually insufficient in providing relief. Depending on the frequency of paracentesis required, this may need to be followed by colloid volume therapy (i.e. albumin). A referral to the BC Cancer Agency for consideration of chemotherapy or radiation therapy may be indicated for certain cancer related causes of ascites.

If clients are requiring frequent drainage of ascites fluid, indwelling peritoneal catheters can be placed. These are managed on an outpatient basis or in the home in many communities across the North.

Ascites is a common occurrence in the end stages of many diseases. It is important to identify it early and manage it appropriately. Management should include trying to identify the underlying cause, treating the underlying cause if appropriate and treating symptoms associated with the ascites. Please contact the Palliative Care Nurse Consultant in your area for guidance and support if you are unsure of how to best manage your client.

References:

Downing, M. (2006). Medical care of the dying. (4th ed.). Victoria, BC: Victoria Hospice Society.

Northern Health (2008) Hospice Palliative Care Symptom Guidelines

Pereira, JL (2008).The Pallium Palliative Pocketbook. 1st ed. P. 8-36 to 8-37

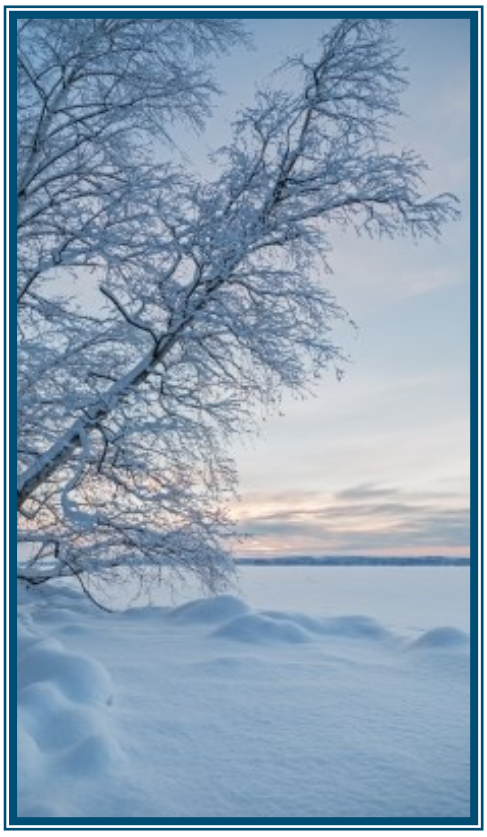

Image by Tuomas_Lehtinen at FreeDigitalPhotos.net

Highlighting the North

guest articles from the region

Tips on Implementing the Palliative Approach in Residential Care

Author: Jennifer Kennedy, RN, BSc, BScN, MN

Acropolis Manor (AM) is a complex care facility in Prince Rupert, BC with spaces for 56 admitted residents and room for five more people temporarily. Our staffing mix is licensed practical nurses (LPNs) as Team Leaders and health care assistants (HCAs), with most of the personal care being provided by the HCAs. With respect to palliative care, we are supported by the Northern Health (NH) Palliative Care Consultation Team - a decentralized team with our remote members in Smithers, Prince George, Dawson Creek and Fort St. John.

In 2015, AM joined the Call for Less Antipsychotics in Residential Care (CLeAR) initiative; however, our use of antipsychotic medications was very appropriate – it was more the culture change process CLeAR was supporting that we were wanting. Why? Observations of resident care at AM showed us we were often very task-driven in our care for residents. Also, even though most personal care for the residents was provided by HCAs, there was no formal way for them to share their care priorities or concerns with other members of the team. How do you change culture, we wondered? CLeAR initiative teams that went before us identified regular daily huddles as the most effective way to change culture.

In October 2015 we launch *podTalks* as our version of daily huddles. Then, to focus on a team model and get the most improvement benefit for the residents, we use the *podTalks* method to plan and deliver palliative approach education for all staff. We were also fortunate that Prince Rupert Hospice Society wanted to establish more of a role for their volunteers at about the same time and so we joined with them to train their volunteers alongside our staff - building our capacity to improve care for the residents. It is a win-win partnership.

When considering palliative approach education for our situation, we talked with Kath Murray, a former nurse at Victoria Hospice Society, who had just completed writing a wonderful textbook about the palliative approach, beautifully illustrated, and aimed at HCAs. After our conversation, we knew her vision for education mirrored our vision for care for the residents of AM. After some intensive planning together that included the staff, we delivered the text book curriculum in ten sessions from February to May 2016; one session during *podTalks* each week,

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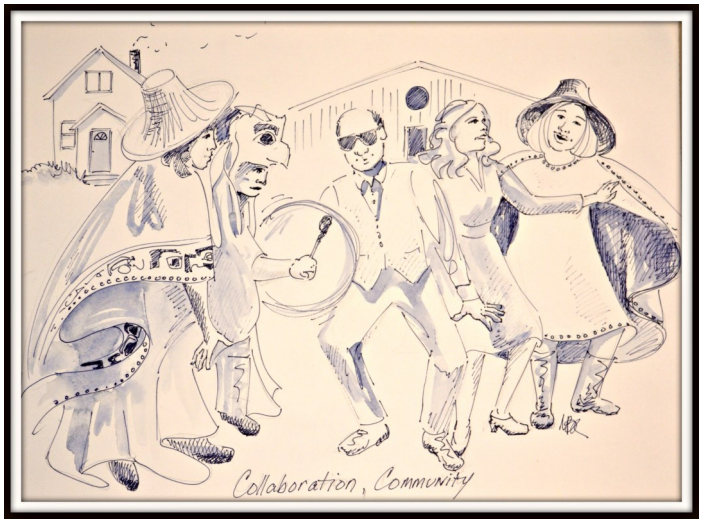
that was repeated again in the same week during an hour session for the Hospice volunteers and any staff who hadn't been able to attend *podTalks*.

From the outset, we planned wrap-up sessions with Kath and her social work & facilitator colleague, Elizabeth Causton; one session during the day and a second session in the evening for community and family members and Hospice volunteers. And, we wanted to capture a visual legacy of the day and we are grateful for the artistic renderings so beautifully done by Nicole Best Rudderham - some reproduced here.

Where are we now, nearly five months later? To sustain the learning, we're compiling the skill components of the palliative approach curriculum and putting them into a document that we will use to keep the learning fresh. An observation card as part of this document serves as an audit tool for new staff so they become familiar with the palliative approach. The audit data also tells us how we're doing at maintaining the skills of the approach over time.

And, what about our evaluation of improved resident care through improved team-based care? We've found that we're better at identifying residents who are frail and who are therefore more likely to be imminently dying than we were before we began. We're also better at linking them and/or their families with a Hospice volunteer, if that's their wish.



Generally, we're also better at consulting, assessing residents' symptoms and sharing information among team members. We consult with our NH Consultation team member earlier; we more readily communicate with families and physicians about care and that's made us better at switching to palliative orders earlier. Using a handy symptom assessment tool focused on HCA practice has helped us improve relieving people's symptoms earlier, too, pain in particular. Finally, we readily discuss residents' plans of care among team members at *podTalks* and I like to think that translates into a tangible improvement in person-centred care.

It has been and it continues to be a learning journey. We hope these 'tips' give you confidence and the support you may wish for when you are planning to implement a palliative approach in the facility where you work and lead. If you see value in having any of the work we've done be available to you, please just ask.

On behalf of the staff at Acropolis Manor and the Prince Rupert Hospice Society volunteers,
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Helping people stay connected to who they are or who they want to become

Atul Guwande; 2014.

Education Opportunities

Palliative Care Education Sessions

WebEx/Teleconference

A team of experts in palliative care will be presenting a series of interdisciplinary webinars on palliative care. All health professionals from all care settings are invited to attend. A specific subject will be taught each month and repeated throughout the month to allow more people to participate. Webinars are recorded and provided on OurNH and the external website.

Month	Dates	Topic	Presenter
January 2017	Thurs, Jan 5, 2-3 pm PST Wed, Jan 11, 3-4 pm PST Thurs, Jan 19, 2-3 pm PST	Music Therapy in Palliative Care	Annette Rolleman AMT
February 2017	Thurs, Feb 2, 2-3 pm PST Wed, Feb 8, 3-4 pm PST Thurs Feb 16 2-3 pm PST	Decision Making in Palliative Care LEAP Core	Annie Leong Palliative Nurse Consultant
March 2017	Thurs, Mar 2, 2-3 pm PST Wed, Mar 8, 3-4 pm PST Thurs, Mar 16, 2-3 pm PST Wed, Mar 22, 3-4 pm PST	Principles of Palliation Integrating a Palliative Approach	Seth Gysbers Palliative Nurse Consultant
April 2017	Thurs, Apr 6, 2-3 pm PST Wed, Apr 12, 3-4 pm PST Thurs, Apr 20, 2-3 pm PST	Palliative Sedation LEAP Core	Jenna Hemmerich Palliative Nurse Consultant

Please note: schedule subject to change

If you are interested in having your name added to our distribution list, please contact Sandra.Schmaltz@northernhealth.ca.

Image by Sandra Stanley