MINISTRY OF HEALTH

GUIDELINES ON PALLIATIVE CARE FOR CANCER AND AIDS PATIENTS

MEDICAL PUBLISHING HOUSE

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HANOI, 2006

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MINISTRY OF HEALTH

No: 3483/QĐ-BYT

SOCIALIST REPUBLIC OF VIETNAM
Independence - Freedom - Happiness

Hanoi, 15/9/2006

DECISISON

On the issuance of the guidelines on palliative care for cancer and AIDS patients

THE MINISTER OF HEALTH

Pursuant to the Government's Decree No. 49/2003/ND-CP of May 15,2003 defining the functions, tasks, powers and organizational structure of the Ministry of Health;

Based on the document submitted on the date 14/9/2006 by the scientific committee on development of the guidelines on palliative care for cancer and AIDS patients that established by the Minister of Health No 2601/QĐ-BYT of 24/7/2005;

At the proposal of the Director of Therapy Department,

DECIDE

Article 1. Issuarance attached with this Decision the Guidelines on palliative care for cancer and AIDS patients" .

Article 2. "Guidelines on palliative care for cancer and AIDS patients"can be used in all sate, private clinics.

Article 3. "Guidelines on palliative care for cancer and AIDS patients" is a document to be used for guidance of palliative care for cancer and AIDS patients at home and community.

Article 4. This Decision shall come into effect 15 days after the date of its signature.

Article 5. Chief cabinet, the Director of Therapy Department, Chief Inspector, Director of Department under the Ministry of health, Directors of Institutes and Hospital under the Ministry of Health , Directors of provincial health services and relevant sectors shall be responsible for the implementation of this Decisison.

Recipients:
- As stated in Article 5
- Office of the Government
- Minister of Health
- Deputy Ministers of Health
- Archive

DEPUTY MINISTER OF HEALTH

(Signed)

Nguyen Thi Xuyen

MINISTRY OF HEALTH

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GUIDELINES
ON PALLIATIVE CARE FOR CANCER AND AIDS PATIENTS

(*Issued with Decision No. 3483 /QD-BYT September15, 2006 of the Health Minister*)

CHAPTER I
INTRODUCTION TO PALLIATIVE CARE FOR CANCER AND AIDS PATIENTS

I. CONCEPTION

Palliative care for cancer and AIDS patients is a combination of measures to relieve suffering and improve the quality of life of patients through the prevention, early detection, treatment of pain and other physical problems, providing counseling and support to address psychosocial that the patient and their family are encountering.

II. PRINCIPLES

1. General principles

a) Provided to all cancer and AIDS patients;

b) Provided from early stage throughout the continuum of illness (figure 1);

c) Provided in combination with other specific treatments;

d) Promote treatment adherence and can reduce adverse effects of specific treatments;

e) Helps patients to have good quality of life to the end of their life;

f) Consider life and death a natural progression with no intention to speed up nor unduly slow down the death;

g) Psychosocial care is crucial component in palliative care;

h) Assist the family during the patient's illness and after the loss of family;

i) Used interdisciplinary teams approach, in which the patient is centered with the participation of health care workers, family members, social workers, volunteers, etc;

j) Implemented at healthcare settings, at home and community.

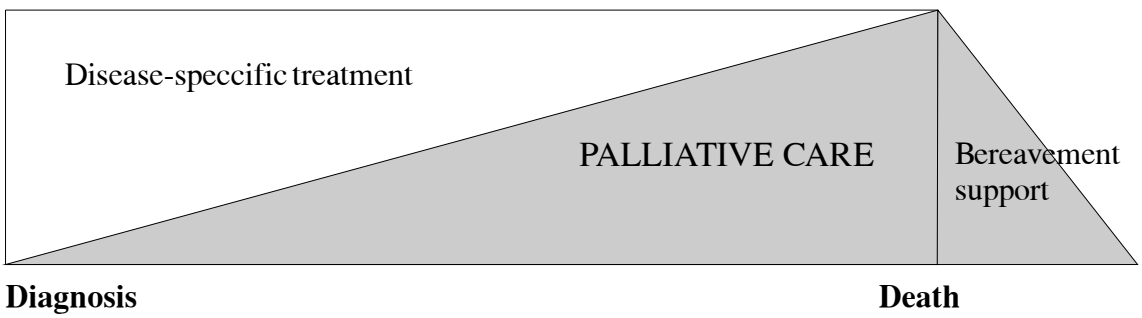


Figure 1: Diagram of palliative care throughout the course of illness

2. Principle of "Double Effect"

a) Any treatment method may cause bad effects. If desired by a terminally ill patient, medications intended purely to provide relief from severe pain or other symptoms may be used even at the risk of foreseen but unwanted side effects.

b) This principle is often the case when providing care to terminally ill patients in order to determine the optimal treatment when any risks side effects. For example, a terminally ill cancer patient suffering from severe pain and difficulty to breathe can be prescribed with high-dosed opioids even at the risk of sedation, hypotension, and respiratory depression.

c) Four conditions for applying "Double-Effect" principle:

- The treatment decision itself must be moral;
- The sole purpose of the treatment is the good effect, like relief of pain and suffering for terminally ill patients;
- The unintended bad effect of the medication (causing death) must not be considered as the means to the good effect (comfort);
- Potential benefits of the medication must outweigh the bad.

III. APPROACH TO PALLIATIVE CARE

1. Symptom relief

a) Symptoms causing discomfort happen very often to cancer, AIDS and other life- threatening diseases. Symptoms can at different disease stages, related to the progress of the main disease or unwanted side effects of treatments. These symptoms must be detected actively and early, and fully cared in order to alleviate suffering for the patient, improve their life quality and assist the treatment of the main disease.

b) Symptoms causing discomfort are often related to specific physical or psychological causes. It is advisable that symptom causes be identified through thorough history taking, careful consultation, and necessary lab analysis and exploration.

c) Many symptoms are individual patient's experience which cannot be assessed through clinical consultation or paraclinical exploration. Health care workers should respect what is described by the patient rather than base on their own subjective assessment. Symptom assessment is more difficult with some types of patients like children who have yet to speak or cognitively impaired adults as they are unable to describe their feelings and the level of discomfort. In such cases, one should base on signs detected via physical assessment and reports by the care givers.

d) One should identify the level of emergency of the symptoms so as to provide timely and intensive treatment. In some instances, treatment should be provided immediately to the suspected cause which has most suggesting symptoms, without waiting for lab test results to confirm.

Main steps of symptom assessment

Taking history

- Symptom progression: occurrence, frequency, intensity, characteristics, factors that increase or relieve symptoms, impacts of symptoms on body functions. It is necessary to note causes to the symptoms assessed by the patients.
- Previous treatment and its efficacy;
- Social factors: family (members and living circumstances etc.), impacts of the disease and symptoms that the patient currently has on the family, the patient's quality of life, history of substance abuse;
- History of allergy to medicines;
- Medicines currently used.

Physical assessment

- Comprehensive consultation, special attention to affected areas
- Assessment of symptom impacts on body functions and affected organs, including emotional and psychological being of the patient
- Assessment of severe and emergency level of the symptoms
- Preliminary identification of causes to the symptoms.

Assessment of lab results and paraclinical exploration

Development of differential diagnosis

đ) Symptom management is most effective when causes to the symptoms are treated. In some cases, symptoms can be relieved after the patient receives disease-specific treatments (i.e. ARV for AIDS patients or antibiotics for opportunistic infections, chemotherapy for cancer patients). Palliative care can help rapidly and effectively alleviate symptoms before disease-specific treatments take effects.
e) All treatment and care must be provided on voluntary basis, suitable to the illness and patient's circumstances.
f) One should be fully aware of the side effects and potential toxicity of the medication and to minimize such unwanted effects.

2. Pediatric Palliative Care

Provision of palliative care for children requires should consider the stage of physical, cognitive and emotional development of childhood and special skill in consultation and assessment of symptoms. Many children with HIV/AIDS will have experienced the loss of one or both parents. Therefore, bereavement care is an important part of palliative care.

CHAPTER II
PALLIATIVE CARE PRACTICE
FOR CANCER AND AIDS PATIENTS

I. PAIN CONTROL

1. Pain conception

Pain is the feelings of discomfort of a patient because of current or potentia tissue damage, or is described as actual injury that the patient is suffering to.

2. Classification and Causes of Pain

2.1. Classification of pain: There are 2 major categories of pain:

a) Nociceptive pain: is caused by the stimulation of intact nociceptors in afferent nerves. Nociceptive pain is further subdivided into somatic and visceral pain:

- *Somatic pain:* nociceptors in the skin, soft tissues, muscle, bone are stimulated, and are often localized. Pain in the skin is often sharp, strong burning, throbbing. Pain in the muscle and bone is often gnawing, dull.

- *Visceral pain (internal organs and hollow viscera)*: nociceptors in organs are stimulated due to metastasis, block, swollen or stretched organs. This pain is often non-localized and causes feelings of being compressed.

b) Neuropathic pain: is caused by damage to nerve tissue. Pain is strong burning, with the sensation of electric shock, numbness, allodynia (pain due to stimulus such as light touch) in the area affected by the nerves.

2.2. Causes of pain

a) Actual tissue damaged: From infection, inflammation, neoplasm, ischemia, trauma, invasive medical procedures, drug toxicity, etc

b) Potential tissue damage: Recognized disease entities where no tissue damage can be edemonstrated but cause pain, such as fibromyalgia.

c) Psychosocial factors:

Major depression or anxiety disorders can cause or exacerbate physical pain, and physical pain also can be a cause of major depression and anxiety disorders.

- Other psychological syndromes that predispose patients to chronic pain include somatization disorder, conversion disorder, post-traumatic stress disorder, hypochondriasis, and psychogenic pain disorder. Psychological syndromes may dispose patients to pain or make pain worse.

- In some cases, it is impossible to relieve pain without diagnosing and treating the causes, like depression, anxiety or other psychological problems.

3. Pain assessment

a) Taking history: When it starts, how long it last, what makes it better or worse, where is the ocation, does the pain radiate, how intense, description of the pain; previous therapies; history of related illnesses.

b) Assessing the type of pain: (see 2.1)

c) Identification of causes to the pain:

- Physical assessment to identify accompanying illnesses, or syndromes;
- General assessment of psychosocial, emotional, religious factors and daily habits.

d) Determination of the level of pain:

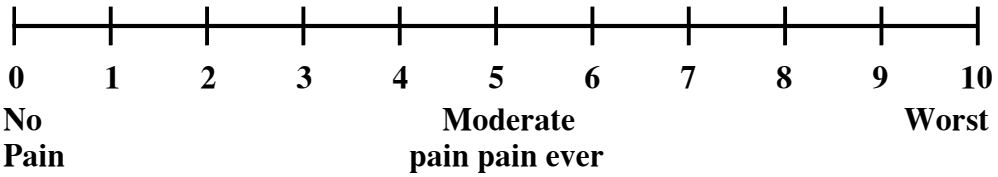
- Based on self-assessment of the patient.
- In order to monitor and compare progress of pain, one pain assessment scale should be used in all visits. One of the following tools may be used.

Note: *Comparing the levels of pain between visits is valid on each individual patient, but not between*

Tool 1: Pain Intensity Scale

- This tool can be used for adults, to determine the pain levels at the current visit as well as pains happened in the past.
- Pain levels from 0-10 can be explained verbally to the patient or can be drawn on a piece of paper.
- Note down the pain level that the patient reports to make treatment decisions, Follow-up, and compare between examinations.

Pain Intensity Scale

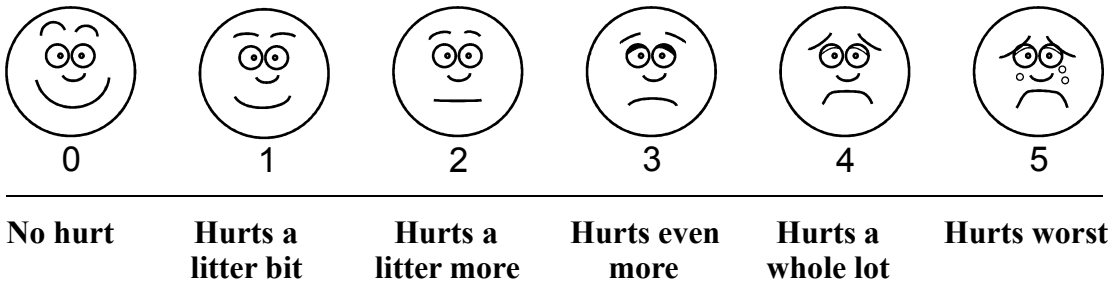


Tool 2: Wong-Baker Faces Pain Rating Scale

- This tool is simple, suitable to children and appropriate to determine pain intensity for the current visit.
- Explain to the patient that each face is for a person who feels happy because he has no pain, or sadbecause he has some a lot of pain, which is reflected through how much mouths, eye browsare curved and in which directions, and the expression of the eyes and faces.
- Ask the patient to pick one face that best describes the current pain intensity.

Note down the pain level that the patient reports to make treatment decisions, follow-up, and compare between examinations.

Wong-Baker Faces Pain Rating Scale



- Results of pain intensity assessment

Pain Intensity	Pain Intensity Scales	Wong-Baker Faces Pain Rating Scale
Mild	1 - 3	Hurts a little bit
Moderate	4 - 6	Hurts a little more Hurts even more
Severe	Above 7	Hurts a whole lot And hurt worts

d) Brief Pain Inventory (Annex 3) is also a common tool used in research on cancer and AIDS patients in clinical settings to assess and monitor pain and the impact of pain on other aspects of the quality of life.
e) Note: Children feel pain and suffering even they don't out warding express they are in pain. Younger children may be unable to report pain. Assessment needs to include observation and carer report.

4. Pain Management in adults and children

a) Any patient who is suffering from pain must be treated to relieve pain and improve their quality of life at any stage in the course of their illness.
b) Pain management is alleviating intensity of pain and preventing pain from recurring. Successful pain management is achieved when the patient feels no more pain, comfortable, and is able to carry out normal activities in their daily life.
c) Management of pain can be conducted in medical facilities, at home and in the community.
d) Respect and recognize patient's description on their pain, efficacy of interventions, even when the patient is using illicit drugs.
e) Use not only pharmacologic but also non-pharmacologic interventions, and always pay attention psychological issues.
f) Individualize pain interventions and doses.

4.1. Pharmacotherapy of Pain

4.1.1. General principles

a) Therapeutic Route: Oral therapy is preferred unless the patient is unable to take oral medication or unless the pain is so severe that more rapid and aggressive parenteral therapy is necessary.
b) Individualize the treatment, correct dose means sufficient to manage his/her pain.
c) Monitor the response closely to maximize benefit and minimize side effects.
d) Use WHO three-step Pain Ladder (figure 2):
   - Mild pain: use non-opioid, and can use with adjuvant pain drugs;
   - Moderate pain: Weak opioid plus non-opioid, and can use with adjuvant pain drugs;
   - Severe pain: Strong opioid plus non-opioid, and can use with adjuvant pain drugs.

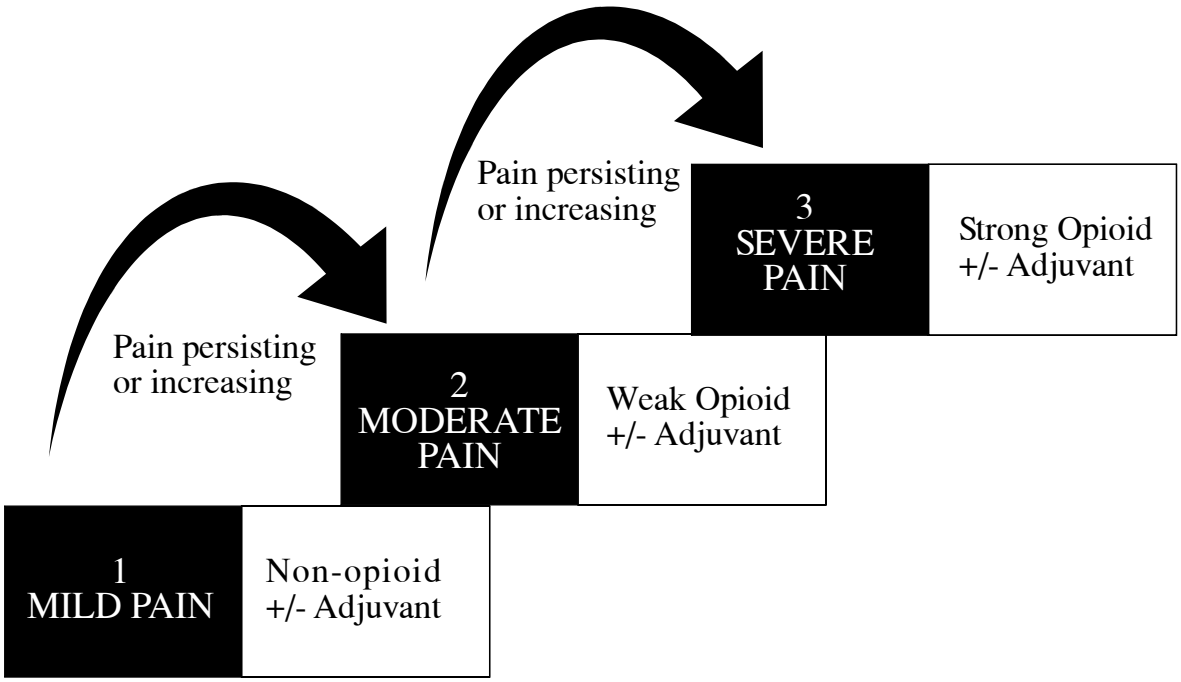


Figure 2: WHO Three-step Pain Ladder

đ) Dosing

- ***By-the-clock dosing:*** Pain medications must be given regularly round-the-clock, at fixed time intervals, the following dose should be taken before the effect of previous dose wears off.
- ***Break-through dosing:*** are the ones that are supplemented to regular doses in order to control incident pain (known as "rescue" dose).
- Most non-opioid pain medications (paracetamol, nonsteroidal - NSAIDS) have a daily dosing limit and can cause severe toxicity when the maximum dose is exceeded. Therefore, the usefulness of non-opioid pain medications to treat acute breakthrough pain is limited.

- Adjuvant pain medications should not be used to treat acute breakthrough pain.
- When using opioids in the outpatient setting, the breakthrough dose should be approximately 10% of the total daily opioid dose.

> *For example, a patient receiving oral morphine 10mg every 4 hours:*
> *- Total daily dose: 10 mg x 6 = 60 mg*
> *- Breakthrough dose: 10% x 60mg = 6 mg every 2 - 4 hours as needed*

- If frequent breakthrough doses are required, the total daily amount of breakthrough pain medication should be added into the regular by-the-clock doses.

> *For example, if a patient who receives morphine 10mg every 4 hours;*
> *Also requires a "rescue" breakthrough dose of 6mg five times during the day;*
> *- Total "rescue" breakthrough dose: 6mg x 5 times = 30mg/day;*
> *- Thus the regular around-the-clock dose can be increased to 15mg every 4 hours*
> - If the patient requires breakthrough pain medication for incident pain such as pain caused when the patient is washed or walks, a breakthrough dose should be given 20 - 30 minutes prior to the inciting cause.

4.1.2. Non-opioid Analgesics

Table 1: Use of Non-opioid Analgesics

Analgesisc / Routes	Starting Dose	Duration	Daily maximum dosage	Comments
Recommended Analgesics:				
Acetaminophen (Paracetamol Tablets, and syrup for children with strength depends on producers) Oral route	Adults: 500 -1000 mg Children: 10 - 15 mg/kg	Every 4-6 hours	4000mg Children: no excess of recommended Dose	- Reduce dose or do not use in patients with liver disease. - May be hepatotoxic if exceeds recommended dose.
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)				
Ibuprofen (Tablets of 200, 300, 400, 600, 800mg; Syrup for children with strength depends on producers) Oral route	Adults: 400-800mg Children: 5-10 mg/kg	Every 6- 8 hours	Adults: 2400mg Children: no excess of recommended	- Prolonged prescription must be added with gastrointestinal prophylaxis. - Lower dosage for patients with severe liver disease.
Alternatives				
NSAIDs				
Choline magnesium trisalicylate Oral route	Adults: 500-1000mg	Every 8-12 hours	Adults: 3000mg	- No inhibition of platelet function - Less gastrointestinal toxicity. - Reduce dose in patients with renal failure
	Children: 25mg/kg		Children: no excess of recommended dose	
Diclofenac (immediate release) Oral route	Adults: 25-75mg	Every 12 hours	200mg	- Prolonged prescription must be added with gastrointestinal prophylaxis. - Reduce dose in patients.with renal failure

Diflunisal Oral route	Adults: 500mg	Every 12 hours	1000mg	
Etodolac (immediate release) Oral route	Adults: 200-400mg	Every 8 hours	1200mg	
Fenoprofen Oral route	Adults: 200mg	Every 6 hours	3200mg	
Ketoprofen (immediate release) Oral route	Adults: 25-75mg	Every 6-8 hours	225mg	- No longer than 5 days. - Prolonged prescription must be added with gastrointestinal prophylaxis. - Reduce dose in patients with renal failure.
Ketorolac IM/IV Oral route	Adults: - High dose for the first time 30-60mg, followed by 15-30mg; or - Oral: 10mg	Every 6 hours	-Injection: 120mg - Oral: 40mg	- Danger of gastrointestinal hemorrhage. - Short course (5 days at most). - Prolonged prescription must be added with gastrointestinal prophylaxis. - Reduce dose in patients with renal failure.
Meloxicam Oral route	Adults: 7,5-15mg	Every 24 hours	30mg	- Prolonged prescription must be added with gastrointestinal prophylaxis. - Reduce dose in patients with renal failure.
Piroxicam Oral route	Adults: 20mg	Every 24 hours	20mg	- High risk of gastrointestinal hemorrhage. - Prolonged prescription must be added with gastrointestinal prophylaxis. - Reduce dose in patients with renal failure. - Do not use in patients with liver disease.
Opioid-alike Analgesics				
Tramadol Oral route	Adults: 50-100mg	Every 4 6 hours		An analgesic that has similar effects to weak opioid.

Prevention of NSAIDs' common side effects:

- **Gastric Ulceration**

  - In the case of history of digestive hemorrhage, gastric ulcer, or unidentified pain in the upper stomach, only prescribe paracetamol to relieve pain. When needed, NSAIDs always should be used with H2-receptor antagonists or Proton pump in hibitor (omeprazol), and the least toxic medicines to stomach and intestine (Choline magnesium trisalicylate).

  - Stop medications if there is pain in the upper stomach, feelings difficult to digest, black or blood stool.

- **Hepatic Failure:** No prolonged prescription in patients with hepatic problems;**Renal**
- **Failure:** used with caution in patients with renal disease.
- **Hemorrhage:** Use Paracetamol or Choline magnesium trisalicylate to relieve pain in patients who are thrombocytopenic or is bleeding.

4.1.3. Pain Control with Opioid Analgesics

4.1.3.1. Some important conceptions:

a) Opioid tolerance: a phenomenon when a fixed dose of drug produces a decreasing effect so that a dose increase is required to maintain stable analgesic effect. Opioid tolerance occurs in all chronic opioid therapy, Which is not pathological.

b) Opioid dependence: a state in which withdrawal symptoms occur when the drug is stopped suddenly or reversed with an opioid antagonist. Opioid dependence occur in all chronic opioid therapy, which is not pathological.

c) Opioid addiction: a disorder characterized by compulsive use of a drug resulting in physical, psychological, and/or social dysfunction to the user and by continued use despite this dysfunction.

d) Pseudoaddiction: drug-seeking behavior resulting from inadequate treatment of pain by physicians that resolves when pain is adequately treated. Must be distinguished from true addiction in which drug-seeking behavior continues despite adequate analgesia.

4.1.3.2. Long-acting opioids

a) If available, long-acting opioids are preferable for treating chronic pain, because they maintain a more constant blood-level of the drug and thus a more constant state of analgesia than short-acting opioids.

b) Long-acting opioids include 12-hour oral formulation of morphine, oxycodone, and hydromorphone, and the 72-hour fentanil transdermal patch.

c) Long-acting opioid should be used only by-the-clock, never as treatment For breakthrough pain. A short-acting opioid ideally the short-acting form of the long-acting opioid should be used for breakthrough pain.

4.1.3.3. Opioid analgesics

Table 2: Use of Weak opioids

Analgesics, Route	Staring Dose	Duration	Comments
Codein (30mg tablet, or combined with non-opioid like aspirin, paracetamol) Oral route	Adults: 30-60mg Children: 0,5 - 1 mg/kg	Every 3 - 4 hours	- Maximum dose of 360mg per day; for children not excess 6 times per day - May cause constipation - Often cause nausea - Reduce dose in patients with renal failure.
Dextropropoxyphene Oral route	Adults 65mg	Every 4 hours	Cause toxic metabolite

Table 3: Use of Strong opioids

Analgesics, Route	Staring Dose	Duration	Comments
Morphine sulfate immediate release Oral route	Adults: start with 5 mg, re-assess after 30min, then can increase to 10mg	After identify dose, every 4 hours	May increase by 1.5-2 times after each day if pain is refractory
	Children: start with 0,15mg/kg, then can increase to 0,3mg/kg		
Morphine sulfate Long acting Oral route	Adults: 10-15mg	Every 12 hours	
Morphine clohydrate IV or SC	Adults: 2-5mg	Every 3-4 hours	
	Children: 0,05 - 0,1mg/kg		
Oxycodone immediate release Oral route	Adults: 5-10mg	Every 3-4 hours	More potent than morphine.
	Children: 0,1mg/kg		
Oxycodone Long-acting (Oxycontin) Oral route	Adults 10mg	Every 12 hours	
	Children: 0,1mg/kg		
Hydro-morphone Oral route	Adults: 1 - 3mg	Every 3-4 hours	More potent than morphine.
Hydro-morphone IM or SC	Adults: 0,5 - 1mg		
Fentanyl Transdermal patch (Duragesic)	Adults: 25mcg/h	Apply one patch for 72 on chest and thigh	- Use only for chronic pain, not for breakthrough pain. - Dot not prescribe for patients with fever, sweating, or cachexia. - Suitable to relieve pain in very weak patients who are unable to take oral medications or get injected regularly. - Provide other quick-acting analgesics until the patch takes effect after 12-18 hours. - Very expensive, difficult to store (cold) in hot and humid condition.

Table 4: Conversion from other opioids to morphine

From other oral opioids to oral morphine	From other injected opioids to injected morphine
Hydromorphone Dose x 4	Hydromorphone Dose x 6,7
Codein dose x 0,15	Codein dose x 0,08
Oxycodone dose x 2	Fentanyl dose x 100

Table 5: Conversion from injected morphine to Fentanyl Transdermal Patch

Injected morphine (Mg/24 hours)	Durogesic (mcg/hour)
18-35	25
36-59	50
60-83	75
84-107	100
108-131	125
132-156	150

4.1.3.4. Side Effects of Opioids

The risk of serious side effects of opioids is minimal when standard prescribing rules are followed.

a) Should prescribe the lowest dose of opioid that either relieves the pain completely or to the degree acceptable to the patient should be used.

b) One of the most common side effects of opioid analgesia is constipation which can itself cause pain and discomfort. Therefore, patients receiving an opioid analgesic who do not have diarrhea should receive prophylactic treatment for constipation.

c) Sedation virtually always precedes respiratory depression. Therefore, it is safe to treat pain aggressively with opioids at least until sedation occurs.

d) Sleepiness when starting an opioid or taking an increased dose is not always due to opioid-induced sedation. Many patients with persistent or frequent pain are sleep-deprived and will go to sleep when their pain is adequately relieved. Normal sleep can be distinguished from sedation by testing the patient's arousability. A normally sleeping patient will be arousable.

4.1.3.5 .Attentions for Discontinuation of opioid therapy

a) Opioid therapy is discontinued when the patient's pain has resolved and sometimes when an alternative type of analgesic therapy is being tried, or when a patient repeatedly breaks an opioid contract (if there is any).

b) When opioid therapy of two weeks or longer is discontinued, care must be taken to avoid causing opioid withdrawal syndrome. Signs and symptoms of opioid withdrawal syndrome include fever, chills, sweating, nausea, vomiting, painful abdominal cramping, diarrhea, muscle aches, insomnia, runny nose, and hypertension, etc.

c) To avoid this syndrome, the opioid dose should be tapered slowly over 23 weeks. When symptoms occur, they can be treated by giving opioid at a dose slightly higher than the previous dose.

d) Opioid antagonists such as naloxone cause opioid withdrawal symptoms immediately in patients taking opioids chronically and can cause a sudden return of severe pain.

4.1.4. Adjuvant Medications for Pain Control

a) Adjuvant medications can relieve pain, enhance effects of and help to reduce dosage of NSAIDs and opioids.

b) Main indications

Corticosteroids: pain due to swelling, inflammation, nerve and spiral cord block

- Tricyclic antidepressants: pain due to damaged nerve tissue causing seizures, allodynia, strainge sensation, and burning
- Anticonvulsants (anti epilepsy): pain due to damaged nerve tissue causing seizures
- Block impulse transmission (local anesthetics) medications: pain due to peripheral nerve damage
- Antipasmotics: pain due to digestive smooth muscle contraction
- Voluntary muscle relaxants: pain due to muscle contractility
- Bisphosphonates: bone pain from bone metastases

Table 6: Use of Adjuvant Medications for Pain Management

Adjuvant and rout	Dose and administration	Side effects
Corticosteroids		
Prednisolone	Adults: 20-80 mg in the morning, orally after meal or IV	Hyperglycaemia, agitation, psychosis, myopathy, digestive problem, etc.
	Children: 1mg/kg x 1-2 times/day, orally after meal	
Dexamethasone	Adults: 8-20 mg in the morning, orally after meal Children: 0.3mg/kg/day x 1-2 times/day, orally after meal	
Tricyclic antidepres-sants		
Amitriptyline	Adults: 10- 25mg (maximum dose 200mg)/day, orally at bed time	Drowsiness, postural hypotension, life-threatening cardiac toxicity with overdose
	Children: 0.5mg/kg once a day. Add 0.2-0.4mg/kg after 2-3 days if needed. Oral, use at bed time	
Anticonvulsants		
Valproate Natri	15mg/kg/day in 3 doses at bed time Maximum: 60mg/kg/day	Causes drowsiness Do not use in patients with liver disease. Reduce dose in old patients.
Gabapentin	Adults: Start with 300mg at bed time. After 2 days, increase to 300mg twice daily, after 2 following days increase to 300mg three times a day. Continue to increase as needed and tolerated.	Drowsiness initially with each increase of dose.
	Maximum dose 3600mg/day. Children: 5mg/kg one per day at bedtime. Increase as needed and as tolerated to 2-3 times perday, then by 2-5 mg/ kg/day.	
Block impulse transmission (local anes thetics) medication		
Lidocain(hydro cloride)	Start with 1mg/kg IV as a loading dose, then increase0,5-3mg/kg, maximum 50-150mg/day	Hypotension, cardiac arrhythmia, muscle weakness
Bupi vacain(hydro cloride)	10-20mg, 3-5 times/day	

Antipasmotics		
Scopolamin(hyoscine) butylbromide	10-20mg, 3-4 times/day, orally; or10mg SC 3-4 times/day, maximum 60mg/day	Anti-muscarin effects including, constipation , dry mouth, tachycardia.
Scopolamin(hyoscine) hydrobromide	10-20mg, 3-4 times/day, orally; or 0.2-0.4mg, 3-4times/day, SC; or 2mg/day continuous SC;	
	or 1.5-6mg/72 hours topical application or transdermal	
Phloroglucinol hydrat 80mg + Trimethylphloroglucinol 80mg Phloroglucinol hydrat 40mg Trimethylphloroglucinol 0.04mg(spasfon)	4-6 tablets/day; or 1-3 vials IM or IV	
Voluntary muscle relaxants		
Diazepam	2-10mg, 2-3 times/day, orally or IV	Drowsiness, locomotor ataxy
Baclofen	Start with 5mg 3 times/day, orally, maximum dose 20mg x 3 times/day	
Bisphosphonates (use for bone pain from bone metastases)		
Pamidronate	60-90mg IV, every 4 Weeks	Hypocalcemia. Brief (1-2 days) fever or flu-like symptoms (less often with acid Zoledronic)
Acid Zoledronic	4mg IV, every 4-8 Weeks	

4.2. Pain in cancer and AIDS patients with opioid addiction

4.2.1. Pain in cancer and AIDS patients with opioid addiction

a) People addicted to opioids and people receiving methadone substitution therapy may have increased sensitivity to pain, this may be due to opioid-induced hyperalgesia.

b) People addicted to opioids or receiving methadone substitution therapy are likely to have developed tolerance to opioid analgesics and are likely to require higher doses for pain relief than people not taking opioids chronically.

c) Some patients with a history of addiction will fear taking opioid analgesics or even refuse to take them because they fear relapse. This fear should be considered in making treatment decision.

d) There is no reason to fear relapse or not to use opioids analgesics in addicted cancer or AIDS patients, especially when they are dying, in pain, or dyspnea.

đ) For people receiving methadone substitution therapy, it is important to note that:

- Methadone dose in substitution therapy (once per day) does not provide pain relief effect.
- Methadone substitution therapy should continue uninterrupted at the usual dose while pain is treated with other drugs, opioid and/or non-opioid.
- The risk of serious side effects from opioid analgesics is no greater in patients receiving methadone substitution therapy than in others and probably is lower.
- It is unlikely that reports of pain in patients receiving methadone substitution therapy are simply an attempt to obtain more opioids because of addiction ("drug-seeking behavior").

4.2.2. Pain treatment in cancer and AIDS patients with opioid addiction

a) For patients with illicit drug addition: can start with weak opioid for mild pain.

b) If after treating with non-opioid, pain is still consistent, opioids should be used. because the patient may have developed tolerance to opioids, higher than normal doses may be required.

c) In patients with pain and a history of addiction who are not dying, measures can be taken to reduce the risk of diversion of opioid analgesics: adherence with medical therapy. When available, urine tests can be used to identify which opioid the patient is taking.

- Limit amount of medication dispensed to the patient at any one time and require the patient to adhere to a fixed schedule for renewing the prescription.
- Assess the patient frequently for any evidence of ongoing drug abuse such as evidence of fresh injection marks on the skin, suspicious changes in behavior, or changes in adherence with medical therapy. When available, urine tests can be used to identify which opioid the patient is taking.
- Use long-acting opioids for chronic pain (if they are available), and may apply directly observed therapy (DOT). Patients receiving DOT with anti-tuberculosis drugs, antiretrovirals (ARV), or methadone can receive their oral long-acting opioid analgesic at the same time. A patient receiving DOT once per day can be given the second dose to be taken 12 hours later.
- Consider making a written, signed "opioid contract" with the patient. The opioid contract should include a clear description of proper and improper medication use; plan for urine test; violation of this contract may result in termination of opioid Treatment. (see Annex 2)

II. SYMPTOM MANAGEMENT

1. NAUSEA/VOMITTING

CAUSE	TREATMENT IN MEDICAL FACILITIES (Select appropriate drugs for treatment decision)	HOME- AND COMMUNITY-BASED CARE
Inflammation in infections, bacterial toxicity, metabolic derangement	- Primperan 10mg/times, 2-3 times/day,orally or IV - Haloperidol 0,5-2 mg/time, 2- 4 time/day, orally or IV or SC - Prochlorperazine: 5-10 mg/time,3- 4 time/day, orally or IV, or 25 mg suppository rectally 2 twice a day - Dexamethasone 8-20 mg/day,in one or two doses, orally or IV (based on toxicity status to indicate)	- Consume soft and rich-in-energy food; offer smaller meals. Avoid foods which have difficult odor or taste to the patient, hot, sour, or richly oiled. Don't let the patient eat while lying. - Encourage the patient to take ORS, or sip tea with sugar, rice water, or drinks that the patient likes (except for alcohol, beer, and soft drink); take drinks slowly and more frequently. - Waiting 1-2 hours after vomiting to eat again. - If patient feels like vomiting due to drugs, taken with foods, if possible. - If vomiting and nausea are side effects of drugs, waiting for some hours after taking drugs to eat. - If flatulence or gas: simethicone 40mg, 1-2 pills orally - Apply gently medicated balm to temple area. - Antiemetic: Primperan 10mg, 1 pill/time, 2-3 times/day, orally - Refer the patient immediately to the health care setting for consultation and proper care if: + Vomiting for more than 1 day + Frequent vomiting + Projectile vomiting with headache + Vomiting content is dark, brown, or with blood
Adverse Drug Reaction	- Diphenhydramine 25-50mg/time, 3-4 times/day, orally or IV - Scopolamine 1,5-6mg apply one patch for 72 hours, or 0.1-0.2 mg SC, every 6-8 hours	
Chemotherapy, radiation therapy to abdominal area	See chapter IV, item II: Care for cancer patients on chemotherapy	
Increased intra-cranial pressure	- Dexamethasone 8-20 mg in one or two doses daily, orally or IV	

Anxiety	- Diazepam 5-10 mg/time 3 times/day, orally, IV or SC - Lorazepam 0,5-2 mg/times,4-6times/day, orally, IV or SC	+ Dehydration: thirsty, dry mouth, passing little and dark urine + Vomiting with fever + Vomiting with jaundice, abdominal pain or flatulence + Drug taking affected
Gastroparesis	- Metoclopramide (primperan) 10 mg/time, 4 times/day, orally, IV or SC	
Distension of liver or ofhollow viscus due to neoplasm	- Concensus consultation to consider surgery indication - Dexamethasone 8-20 mg/day in oneor two doses, orally or IV when toxicityhappens because of liver problem or the neoplasm itself.	
Bowel obstruction	- Venting gastrotomy tube for drainage,fluid infusion, antipasmotic, anti-secretion, antibiotic - Dexamethasone 8-20 mg/day in oneor two doses orally or IV. Indicated incase of necrosis obstruction. - Consider palliative surgery	
Stimulation of vestibular apparatus	- Diphenhydramine 25-50 mg/time,3-4 times/day, orally or IV - Scopolamine 1.5-6 mg by transdermal patch every 72 hours,or 0.1-0.2 mg every 6-8 hours SC	

2. DIARRHOEA

Bacterial or parasitic infection	- Treat the underlying causes with appropriate antibiotics. - Replace fluids and electrolytes	- Encourage and give the sick person ORS (prepare as instruction note in the package), porridges, juice in small amounts. - Encourage the patient to eat; offer soft and rich-in-energy food in smaller meals. Avoid rough, tough, sweaty, hot, fatty food. - Apply medicated balm or warm compress in the abdomen. - Wash frequently, keep the genital and rectal area clean. For incontinent patients, use dry and soft beddings, changeit frequently. Apply cream/ lotion around the rectal area toavoid bedsore. - After passing stool or before preparing food, wash hands with soap and water (see Annex 5). - If the home-base health care worker has eliminated infection (no fever and no blood in stool), can use loperamide pill 2mg, take 2 pills initially, followed by one pill after each loose bowel movement, do not take more than 4 pills/day, and limited to no more than 2 days. If clinical improvement is not observed within 48 hours, discontinue. Loperamide and refer patients to the health care setting. - If diarrhea lasts longer than 5 days, accompanied with fever, or has bood in the stool, severe abdominal pain, the patient becomes even weaker, severe dehydrated (thirsty, dry mounth, passing little and dark urine), broken skin around the rectal area, need to refer the patient immediately to thehealth care setting for consultation and proper care.
Idiopathic, no response to antimicrobial treatment, radiation enteritis, cancer chemotherapy, surgicalresection of bowel and pancreatic insufficiency	- Loperamide 4mg for the first dose, then 2 mg after each loose stool to the maximum of 16 mg per day;or diphenoxylate + atropine (5 mg + 0.05 mg) for the maximum of four timesper day as needed.	
Intermittent bowel obstruction due to tumor	- Dexamethasone 8-20 mg/day in one or two doses orally or IV. Indicated in case of toxicity. - Management similar to bowel obstruction	
Laxative overuse	Stop or reduce dose of laxative	
Use of ARV	See section on care for patients on ARV	

3. CONSTIPATION

Opioid analgesic therapy	- Sorbitol 5g orally maximum 3 times/day - Lactulose syrup 10g/15ml, first dose 15-45ml in one or two dose orally, maintain 10-25ml/day - Bisacodyl 10 mg once or twice daily,orally - For severe cases: naloxone 1-2 mg every 8 hours orally. - Mineral oil 5-30 ml at bedtime orally - Enema or manually disimpact as needed. - Enema with natri biphosphate or paraffin oil once/day	- Offer the patient to drink frequently. - Encourage the patient to eat a lot of vegetables and fruits, fibrous food such as sweet potatoes, banana, pawpaw. - Drink one teaspoon of ordinary cooking oil before breakfast. - Encourage the patient to mobilize - If it is difficult to pass stool, enema with grease or paraffin oil into the rectum. If the patient cannot do by himself, caregiver should assist (wear gloves). - If the patient cannot pass stool for 5 days consecutively, refer to the health care setting for consultation and proper care.
Other constipating medications: anticholinergics, iron	- Discontinue constipating drugs if possible. - Enema as above.	
Low-fiber diet	- Fibrous food and fluids	
Dehydration, nactivity	- Rehydrate and mobilize only if consistent with patient's goals	

4. MOUTH PAIN AND PAIN ON SWALLOWING

Oral thrush (Candida)	- Antifungus - Topical and somatic analgesics (see Pain Management section)	- Oral hygiene: + Clean space between teeth and the mouth after eating with cotton toothpick, gauze, or clean soft cloth soaked with salt water, lemon juice or mouthwash solution . + Brush with soft toothbrush and gargle after meals and before going to bed with lemon juice, salty water, or diluted soda water (half of teaspoonful of salt in one glass of water) or mouthwash solution. - Eat soft food; avoid food which is too hot or too cold, or spicy. Use straw for fluids and food to prevent pain. - In case of pain: paracetamol orally, 0,5g 4-6 times/day . - If the patient feels strong pain, mouth smells bad, and has white patches, feels difficult on swallowing, and in fever refer the patient immediately to the health care setting for consultation and proper care.
Oral and esophagus aphthous ulcer	- Topical lidocaine before eating; topical steroid (Chlorocid-H, Oracort) until resolved if ulcer < 1cm; can ringe mouth with corticoid - Antiflammatory or to reduce swelling like alphachymotrypsin, serratiopeptidase - Clarythromycin 1000mg/day, 7 10 days - If ulcer >1cm and Ulcer Esophagitis, consider prednisilone 40 mg per day orally for one week, taper by 10 mg/week. Total course 4 weeks.	
Herpetic ulcers	- Treat with acyclovir - Pain treatment with topical lidocaine before eating and paracetamol or any other oral analgesic as needed	
CMV Esophagitis	- Treat with ganciclovir - Treat pain with lidocaine liquid 2% or gel 5 ml orally, and diphenhydramine liquid 5 ml before eating. - Oral analgesics as needed.	
Esophageal malignancy	- Topical and somatic pain treatment as above.	

5. DYSPNEA

Pneumonia	- Treat with appropriate antimicrobial. - Opioid-naïve patient: Morphine 5-10 mg orally or 2-4mg IV or SC, every 2-4 hours as needed. If dyspnea is persistent, give by-the-clock every 4 hours with additional breakthrough dose of 5% of total daily dose every 15 minutes as needed.. Increase dose as needed by 33% per dose - If opioid addicted: higher dose of morphine may be appropriate	- Let the patient lie with the head high up; ventilated room or electric fan, wear loose clothes. - Refer the patient to the health care setting for consultation and proper care. - Ptovide care as instructed by health care workers (oxygen, aerosol)
Cardiogenic pulmonary edema	- Diuresis with furosemide. - Treat with morphine as above	
Non-cardiogenic pulmonary edema	- Treat with morphine as above	
Pulmonary hemorrhage	- Treat with morphine as above	
Severe anemia	- Treat cause of anemia - Treat with morphine as above	
"Death rattle" (Accumulation of secretions in upper respiratory tract)	- 107 Hyoscine butylbromide 20mg,every 2 hours orally or SC. - 108 Treat with morphine as above	

6. COUGH

Irritation of broncho-pulmonary tree from infection, malignancy, inflammation, fluid accumulation, aspiration	- Treat underlying cause if possible. - Opioid-naïve patient: Codeine 30 mg every 4 hours orally. Can also use morphine sulfat or any other opioid also effective - If opioid addicted: readjust dose of morphine appropriately - Dexamethason if caused by malignancy or allergy	- Patient should stay in a ventilated place, without cigarette smoke or kitchen smoke. - Offer the patient traditional cough medicines like honey, lemon to steam. - If productive cough: drink a lot of water, or warm tea with honey or with milk-sugar, or local smoothing remedies to loose sputum such as cough syrup, bromhexin, acetyl cystein, etc - Ask the patient to spit in a lid-container. Dispose of the sputum in a latrine. - In patient with chronic, dry cough, use terpin codeine (or terpicod) 2 tablets each time, 3-4 times per day. - If the patient has fever and/or experiences difficult breath, cough out with blood, or cough lasts for more than 2 weeks, or with fever, green or yellow or blood in sputum, or slight fever in late afternoon, refer the patient to the health care setting for consultation and proper care.

7. WEAKNESS/FATIGUE

Infection, malignancy, response to inflammation.	- Treat the underlying cause of fever if possible - Paracetamol 500-1000 mg every 4-6 hours orally or suppository as needed. Don't exceed 4000 mg per day. Reduce the dose in the patient with liver disease. Alternatives: choline magnesium trisalicylate 500-1000 mg two or three times daily orally; ibuprofen 200-600 mg every 6 hours orally as needed. - For severe persistent fever in a dying patient: dexamethasone 4-20 mg per day in one or two doses orally or IV.	- Check the body temperature every 3-6 hours. - Remove any unnecessary clothing and blankets; make sure the sick person is in a well ventilated place. - To cool the body, wipe the body with damp cloth, cool compress on the forehead, armpits and groin. - Paracetamol 500mg orally for fever of 39^{o}C every 4-6 hours, do not exceed 8 tablets per day. - Encourage the sick person to take ORS, rice water or juice. - If still in fever, especially accompanied by headache, vomiting, seizure, mental confusion, diarrhea, weight loss, or the patient is pregnant, refer to the health care setting for consultation and proper care. - Assist the sick person with socio-economic issues in care He/she canot afford food.

8. FEVER

Infection, malignamcy, response to inflammation	- Methylphennidate 2.5-5 mg orlly at 8 AM and at lunch time. - Prednisilone 20-80 mg per day; or Dexamethasone 8-20 mg per day in one or two doses orlly or IV.	- Check the body temperature every 3-6 hous. - Remove any unnecessary clothing and blankets; make sure the sick person is in a well ventilated place. - To cool the body, wipe the with damp cloth, cool compress on the forehead, armpits and groin. - Paracetamonl 500mg orally for fever of 39^{0}C every 4-6 hous, do not exceed 8 tablets day. - Encourage the sick person to take ORS, rice water or juice. - If still in fever, especcially accompanied by headache, vomiting,seizure, mental confusion, diarrhea, weight loss, or the patient is pregnant, refer to the health care setting for consultation and proper care.

9. INSOMNIA

Pain, other distressing symptoms, anxiety, depression	- Treat pain or other distressing symptoms. - Treat depression or anxiety if present. - Diazepam 5-10mg, or lorazepam 0.5-2mg, or chlorpromazine 10-25 mg at bed time orlly; or amitriptyline 10-50 mg at bedtime orlly.	- Determine underlying causes to insomnia. Share and encourage the sick person. Treat pain and other insomniac symptoms. - Set appropriate time for sleep for the sick person. If possible, arrange a quiet, well ventilated place without bright light for the sick person to sleep. - Do not give the sick person strong tea or coffee late in the evening. Provide gentle massaging or soft music before the bedtime, if possible. - If possible, try to practice yoga or meditation - Give rotunda orally with 1-2 tablets at bed time. - If the sick person has not been able to sleep for several consecutive nights, refer to the health care setting for consultation and proper care.

10. AGITATION/DELIRIUM

Psycho-active medications (especially benzodiazepines), hypoxia, hypercapnia, renal or liver failure, systemic or CNS infection, CNS lesion (ischemia, tumor), psychiatric illness (psychotic disorder, dementia), drug or alcohol withdrawal.	- Treat underlying condition if possible. - Haloperidol 0.5-5 mg two to four times per day orally, IV, or SC. Give more frequently for severe symptoms. Alternative: chlorpromazine 10-50 mg two or three times per day orally or IV.	- Take time to listen to the sick person to understand causes of agitation/delirium. Provide emotional support. - Provide relaxing environment for the patient. - Provide massaging or soft music before the bedtime, if possible. - If still no improvement, refer to the health care setting for consultation and proper care.

11. DEPRESSED MOOD, ANXIETY

Pain, dyspnea, Or other distressing symptoms	- Treat pain, dyspnea, Or other symptoms.	- Psychological and emotional support from family members, health staff, friends etc. Encourage the sick person to talk about their feelings and thoughts. - Provide psychosocial support: housing, employment, food, school tuition for children, peer support groups, counseling. - Provide soft music or gentle massaging. - If the sick person is anxious, provide rotunda 5mg orally, 1-2 tablets at bedtime or twice daily. - If at suicide risk, do not leave the sick person alone. - If psychological support doesn't work, or the sick person is in severe depressed mood refer to the health care setting for consultation and proper care.
Psychosocial stressors	- Psychological therapy	
Major depression	- Paroxetine 20 mg per day orally. Increase dose gradually. Usual effective dose 20-50 mg per day. takes weeks to work. - Amitriptyline 25 mg at bedtime orally. Gradually increase dose. Usual effective dose 50-200 mg. Takes weeks to work. - Tianeptine 12.5mg 1 pill/time, 3times daily - Venlafaxine start with 75 mg then increase to 350 mg/day - Venlafaxine start with 75 mg then increase to 350 mg/day.	

Anxiety disorder	- Clonazepam 0.25-0.5 mg once or twice per day orally; or diazepam 2-10 mg two to three times per day orally or IV. - Imipramine 50-100 mg at bedtime orally. Increase gradually to maximum 200 mg per day. Takes weeks to work. Risk of life-threatening cardiac toxicity from overdose. - Panic attacks: Paroxetine 10 mg per day orally. Increase dose gradually. Usual effective dose 20-50 mg per day. Takes weeks to work.	

12. PRURITIS

Dry skin	- Emollient lotion.	- If dry skin, moisturize with aqueous cream such as calamine or Zinc Oxide, petroleum jelly, and vaseline. Put one table spoon of vegetable oil in 5 liters of water when washing the sick person. - Avoid scratching to damage and infect skin. Gently rub the itchy skin with tea or safe herbs, which is commonly used in the area/family, in a cloth bag. - Keep the bathing water for the sick person at the temperature that he/she feels comfortable. Do not rub violently. After a bath, apply on body diluted chlorhexidin (0.05%). - Scabies: apply DEP to lesion areas (except ulcers), apply one in the morning, one in the afternoon, do not take a
Contact dermatitis	High potency topical steroid	
Scabies	- Treat scabies (by scabies type)	
Eosinophilic folliculitis (HIV/AIDS patients)	- Bacteria: Doxycyclin 200 mg/day - Fungus: Itraconazole 200 mg/day - Antiallergy: Loratadin 10-20mg/day - Topical gel (depend on cause): gel erythromycine 2%, ketoconazole solution 2%, benzoyl	

	- Bacteria: Doxycyclin 200 mg/day - Fungus: Itraconazole 200 mg/day - Antiallergy: Loratadin 10-20mg/day - Topical gel (depend on cause): gel erythromycine 2%, ketoconazole solution 2%, benzoyl peroxide solution 10%, metronidazole solution 0,75% twice daily, topically	Shower before use DEP and should not take a bath after the DEP has been applied. The patient should put clean clothes on after each application. Clothing of the patient and of caregiver which contacted directly to scabies need to launder and dry all items under sunshine. - For severe itching: chlorpheniramine orally, 4 mg, 2 times/day or other anti-histamine (according to guidance). - If skin lesions evolve quickly, become red, blisters, and hurt, or get larger, discoloured skin, ulcer or bleeding with somatic symptoms like fever, jaundice, refer to the health care setting for consultation and proper care.
Cholestasis	- Ondansetron 8 mg twice per day orally. - Biliary stent if possible	
Opioids	- Opioid rotation if possible. - Diphenhydramine 12.5-50 mg every 4 hours orally or IV - Hydroxyzine 10-50 mg every 6 hours orally or SC	
Other causes: HIV, malignancy, uremia	- Diphenhydramine or hydroxyzine as above. - Prednisilone 20-80 mg per day orally; or dexamethasone 4-20 mg per day in one or two doses orally or IV.	

13. BED SORES

<table>
<tr>
<td>Stage 1:
Redness in pressured area

Stage 2:
Skin blisters or small open sore

Stage 3:
Skin breakdown, damage to the tissue below the skin.</td>
<td>- Relieve pressure on sore: soft mattress, reposition patient frequently, heel pads or raise heels off bed
- Keep patient dry
- Avoid skin trauma from sliding
- Treat pain
- Semipermeable membrane dressing

- Manage as stage 1&2
- Clean with povidine-iodine 10%
- Sugar povidine-iodine packing
Or hydrocolloid dressing (Duoderm) dressing</td>
<td rowspan="2">- To prevent bedsores, change the sick person's position on the bed often, massage pressure area. After cleaning, apply Zinc Oxide Talcum powder to the irritated area.
- Keep the skin clean.
- Clean small sore gently with salty water or diluted betadine and allow to dry. Clean daily.
- For deep and large sores, fill the bedsores area with pure honey or sugar; cover with a clean light dressing to encourage healing.
- Change the sick person's position, avoid pressure to the sores.
- Use paracetamol if pain.
- Improve nutrition for the patient.
- If the sick person has fever, dark necrosis, malodorous wound, take drugs as indicated by a doctor.
- Put extra soft material such as a soft, clean cotton towel, especially for bed-ridden people.</td>
</tr>
<tr>
<td>Stage 4:
Deep pressure ulcer, damage to the muscle and bone, tendons and joints.</td>
<td>- Manage as stage 3
- For thick eschar or extensive necrosis, surgical debridement or sugar-povidine-iodine packing.
- For malodorous wound, crush metronidazole pill(or open metronidazole capsule) and sprinkle powder on wound (to deodorise).</td>
</tr>
</table>

III. PSYCHOSOCIAL SUPPORT FOR PATIENTS AND CAREGIVERS

1. General issues

a) Psychosocial characters of patients and caregivers

- People with cancer, AIDS or other life-limiting illnesses often suffer from emotional distress and social problems related to their disease because they know that their life is shortened and in poorer quality. Therefore, the patient is usually emotionally depressed and has related social problems. These common problems can include fear of illness and treatment interventions, reduced desire to live, fear of death, guilt, fear of being punished, reduced self-esteem, fear of isolation and loneliness, anxiety about the future and the future of their family, fear of loss in income and poverty, loss of opportunities for children, and loss of social status.
- Caregivers or family members and other loved ones often face many difficulties in providing care for cancer and AIDS patients. This can be related to sadness of losing their loved one, lack of training and skills in providing care, worry related to financial concerns and the future welfare of the family, social isolation and loss of social status. Especially for those caring for a child with a life limiting illness, it can be very difficult for caregivers to cope; they will require significant support.

b) Role of psychosocial support: Psychosocial care is to respond to the emotional and psychosocial needs not only of the patient but also of the patient's family. It also provides support beyond death of the patient through the bereavement process of the family.

c) Role of the palliative caregiver: The role of the palliative caregiver is to assist patients and families in developing healthy coping mechanisms, provide emotional support and improve self-confidence and self-reliance, help to improve relationships between patient, family, friends and peers; and referral to essential social and economic support services.

2. Content of psychosocial support

2.1. Psychosocial caregivers (counsellors)

a) Professional psychosocial caregiver or counselor such as counselor, psychiatrist, psychologist, specialized doctors (cancer, HIV/AIDS), nurses, community health care worker, social worker etc

b) People with or affected by cancer or HIV/AIDS trained as counselors.

c) Respected people such as priests, monks etc trained in pastoral counseling.

d) Home-based care teams trained in counseling

đ) Health care workers who have been exposed to a counseling orientation programme and are preparing the patient for referral to a qualified counselor.

2.2. Qualities Needed to Provide Psychosocial Care

Health care workers need to develop the following personal qualities to have positive relationships with patients, to empathize with their feelings, and respond therapeutically. These characteristics include the following:

a) Trustworthiness: keep sacred patients' confidentiality.

Self-Awareness: Effective health care professionals are aware of their own attitudes, values, and beliefs. In addition, they show openness and respect for the values and beliefs of others.

b) Being Non-Judgmental: Healthcare workers should accept that the life choices of the patient may differ from their own and accept their feelings of judgment but do not allow the judgment to affect their care.

c) Professional: Health care workers do not become socially involved with their patients and caregivers' emotion. This is primarily to protect the health care worker to be emotionally

affected. Health care workers should treat all patients equitably.

d) Ethical: Being ethical includes being honest with patients and making decisions in their best interest. Professionalism and ethical behavior helps patients feel safe and secure.

e) Empathetic: Empathy is the capacity for understanding the feelings, thoughts, and experiences of another person without having them explicitly communicated.

f) Knowledgeable: Health care professionals need to be well-informed about cancer or HIV/AIDS in order to be able to communicate their knowledge to patients. However, need to use simple terms they can understand.

g) Culturally Competent: Culturally competent health care professionals respect the culture and religion of patients and accept that their patients' practices may differ from their own. Effective health care professionals are careful not to impose their personal values and beliefs on patients.

2.3. Counseling tools

a) Active Listening: Active listening involves carefully noticing and attending to both verbal and non-verbal messages. The counselor needs to show their client that they are listening through: nodding, sitting with the patient and making eye contact. The counselor's job is to have the client do most of the talking.

b) Understanding and Empathic Responding: is a smart responding process, understanding the real emotional state, or point of view of the patient. The counselor confirms in words the emotional state that is being communicated through means of verbal and non-verbal language:and Empathic responding involves showing appreciation for another person's, thus encourage them to take active part in the counseling.

c) Maintaining Confidentiality: The patient needs to feel that information they share will not be shared with others without their consent. It is the counselor's role to prepare the patient to be able to communicate the diagnosis to the relevant people. The counselor also can help the family members to cope with the news of the patient's disease.

d) Psychosocial needs assessment: The psychosocial needs assessment helps the health worker or counselor to provide appropriate counseling. Also at each visit, they should assess the patient's psychosocial needs and share the information with other counsellors in the palliative care team, if any. Use the psychosocial assessment questionnaire (Annex 4). It is necessary to conduct psychosocial Assessment and provide basic support to the patient. In some cases, refer the patient to a psychological expert or a mental health doctor.

2.4. Psychosocial intervention

2.4.1. Building a Therapeutic Relationship

It is ultimately the genuine relationship between the healthcare worker and the patient that not only creates positive change and growth in the patient's life but also assist the patient to adhere and improve efficiency of other therapies. A therapeutic relationship develops through the following stages:

a) Relationship Building: Building the relationship should happen since the first visit.

The health care worker should greet patients by name, be warm and friendly ,and take a few extra minutes to talk informally at the beginning of the visit. This builds trust and rapport in the relationship.

b) Identifying Patient Concerns: Next, the provider can ask about the patient's concerns. Ask questions that make the counseling as a normal talk, listen to the problem described by the patient, ask clarifying questions.

c) Exploring Options: Once patients' needs and concerns have been identified, their options can be explored. Help the patient to identify their own possible responses or solutions to the problem.

d) Implementing Solutions: Help the patient to decide on a solution, and summarize their planned next steps with them.

2.4.2. Possible Counseling Scenarios

a) Preparing to disclosure illness to family, loved one: the health care worker assist the patient in disclosing their cancer or HIV diagnosis to their loved ones.

b) Counseling on treatment interventions: various interventions (ART for HIV/AIDS patients, chemotherapy, radiation or radiotherapy for cancer patients), treatment goals and adherence's important role.

c) Positive living counseling

d) HIV prevention counseling (especially for sexually active people).

đ) Counseling for caregivers of patient

e) Support counseling for family members.

g) Preparing client for death and saying goodbye

h) Bereavement counseling for the patient and the family

2.4.3.MakingReferrals

Referring the patient with HIV/AIDS or cancer to other services is often necessary as not all needed psychosocial services are of ten provided by one service.

a)Appropriate referral points

Referral points depend on the level and type of psychosocial care or service required. They may include: PLHA or cancer support group; Home-based care team; Specialized clinics, hospitals or hospice care; spiritual leaders, social support agencies (housing, job support); child protection and care; legal agencies or local administration and Information-giving agencies.

b)Ensuring the referral system runs smoothly

To ensure the referral is in line with needs and actual ability, need to consider the following issues:

- Obtaining the consent of the patient to the sharing of information between care team partners (if any).

- Giving detailed information to know and see whether it is suitable to the patient's need or not. Distribute a standardized and regularly updated directory on referral and networking points (if any).

- Take patient to referral services to facilitate their access to needed care

- Provide accurate written and verbal historical information to the referral point

- Advocate for the rights of patients with HIV/AIDS and cancer

- Strengthen the existing referral system

- Develop standardized networking and referral procedures of all components of care

3. Psychosocial care for children

Caring for children with cancer, infected or affected by HIV/AIDS is very emotionally difficult for families and palliative care providers. Children need continuous psychological support to cope with the situation. Some of the issues to be aware of as a care provider are:

a) Social interaction: Involve sick children, including those with HIV/AIDS and cancer in all childhood activities. This includes attending school, making friends and being involved in community activities and traditions.

b) Playing: Sick children need to play or watch others play if they are too weak

c) Spiritual care: Spiritual care and/or praying can bring hope, reconciliation and acceptance to the child and caregiver

d) Showing love: Showing love and affection while caring for a sick child promotes healing, eases physical pain and provides psychological comfort

4. Providing care to caregivers

Caregivers are people who provide ongoing assistance or support to patients. Caregivers may be friends, family members or neighbors or a combination. They are valuable resources in palliative care. In practice, care givers needs have often been neglected by health and social service agencies and their role in caring has generally been taken for granted. As a result, caregivers are often very stressed, under-trained, and physically and mentally tired.

4.1. Psychosocial need assessment

Use the following tool to assess the psychosocial needs and stress of caregivers:

a) Because of the time you spend with the patient you do not have enough time for yourself?
b) Stressed between caring for the patient and trying to meet other responsibilities (work/family)?
c) Stressed between caring for the patient and trying to meet other responsibilities (work/family)?
d) Angry when you are around the patient?
e) The patient affects your relationship with family members or friends in a negative way?
f) That your health has suffered because of your involvement with the patient?
g) That you do not have as much privacy as you would like because of the patient?
h) That your social life has suffered because you are caring for the patient?
i) That you have lost control of your life since the patient's illness?
j) Uncertain about what to do about the patient?
k) You should be doing more for the patient?
l) You could do a better job in caring for the patient?

4.2. Recognizing danger signs to refer

4.2.1. Work overload

The strains on those caring for people with AIDS or cancer are enormous. Much of the care provided is by lay caregivers within families and communities. The quality of care they provide and their ability to do so over a sustained period depend on the protection of their own well-being and morale. Care for the caregivers is rarely given the priority it deserves, and "burnout" is a serious problem.

4.2.2. Recognizing signs of burnout

If the caregiver identifies with any of the following symptoms, it may be necessary for respite time away from the caregiving role:

a) Irritability, anger
b) Emotional numbing - lack of pleasure
c) Withdrawal from others - avoidance of patients and problems
d) Irrationality, mood swings or depression
e) Poor sleep, fatigue
f) Poor concentration
g) Resorting to alcohol or drugs

4.3. Psychosocial support interventions

4.3.1. Supporting services

At palliative care facilities (Hospital, Hospice and Home-based Care Teams), caregivers should be provided with:

a) Training on caring skills
b) A safe environment
c) Chances for regular group discussion to discuss staff stress issues
d) Advice for managing workload
e) Measures to prevent work overload

4.3.2. Prevent burnout

a) Be confident in their skills and resources to care for the patient and family;
b) Define for themselves what is meaningful and valued in caregiving;
c) Discuss problems with someone else;
d) Be aware of what causes stress and avoid to much exposure to the stressful stimulus;
e) Use strategies that focus on solution to problems rather than emotions;
f) Change approach to caregiving, such as divide tasks in to manageable parts (small acts of care), learn to adjust to the pace of care giving - relinquish the need to control outcomes. Act as a facilitator for care rather than taking responsibility for everything;
g) Share problems, experience and joy with colleagues;
h) Practice self care by making time regularly for relaxing and enjoyable activities and getting appropriate rest and nutrition.
i) Arrange a bed in the hospital or hospice (if any) for fix schedule respite.

4.3.3. For family

a) To train family members take care of the patient;
b) To prevent infection (including HIV and Ois);
c) To have confidence in their skills to care for the patient and family;
d) To define for themselves what is meaningful and valued in caregiving;
e) To recognize that anger from the patient toward the caregiver is not directed at them personally but may be part of coping strategy;
f) To develop a system of sharing the workload between caregivers or family members in order to provide the main caregiver with breaks.

CHAPTER III
PALLIATIVE CARE FOR THOSE WHO ARE ON ANTIRETROVIRAL MEDICATIONS (ARV) FOR AIDS

ARV treatment is for life, and often causes side effects. Those who are on ARV are at the stage where his/ her immune system is seriously suppressed and many complications of AIDS occur that can badly affects his/her life quality. Thus, People on ARV should be provided with psychological and treatment adherence support, and have side effects and toxicity of the medications promptly detected and addressed.

I. PSYCHOLOGICAL SUPPORT

1. Psychological manifestation

In addition to other psychological issues due to HIV infection, people on ARV can have following psychological concerns:

a) Worried because they think that their health is now seriously deficient and that they are at the last stage of the disease;

b) Worried about the side effects and toxicity of the medications that others on ARV have experienced; unsured whether the regimen will suit, or the virus will become resistant to the drugs they are taking, and in that case whether they can have access to other drugs;

c) Unsured if ARV will improve their health status and prolong their lifetime, this concern is particularly intensed at regular health checkup and CD4 count;

d) For they have to take medications every day, they fear being spotted by others around and thus their status being suspected;

e) Preoccupied by financial ability as they have to pay for the medications and test (if they do not receive free treatment)

2. Supporting counseling

a) Health workers need thoroughly assess and appropriately provide counseling on psychological and social issues;

b) Counsel the patient and their families on meaning and effectiveness of ARV to the health of the infected people;

c) Thoroughly counsel on the regimen that the patient will be on and the possibility of side effects of each drug used in the regimen;

d) Together discuss with the patient about the plan for ARV to the patient's convenience and situation;

e) Refer the patient to existing supportive services in the community, such as PLWHA support groups, or those provided by mass organizations;

f) Refer and make the best use of free ARV sources and testing services, or refer them to other social support where the patient has financial difficulty.

II. ADHERENCE SUPPORT

1. Factors affecting adherence

a) The disease is not yet cured: which becomes a life-long psychological burden. It is for those who lack self-respect and hope to be discouraged, or to stop or skip doses, which leads to treatment failure.

b) Many pills: The number and sizes of tablets/pills, and the course of treatment make treatment adherence difficult for some patients

- Treatment and prophylaxis to opportunistic infections (OI) require the use of many types of drugs, especially in patients with TB;
- ARV requires at least 3 types of drugs and life-long treatment.

c) Adverse effects and toxicity: The patient is afraid of taking drugs, loses confidence in their health. Thus they may stop or skip doses.

- OI prophylaxis (commonly with Co-trimoxazole): may cause fever or rash;
- TB medications: may cause hepatitis, allergy, rash and itching, peripheral or optic neuritis.
- ARV may cause various side effects, such as fever, rash, vomiting, nausea, digestive disorder, headache, sleeping disorder, hepatitis, pancreatitis, peripheral neuritis, anaemia, kidney stone, hematuria, lipodystrophy, etc, In rare cases life-threatening Stevens Johnson Syndrome.

d) Support from family, friends, and health workers: is an important factor for treatment adherence. Sharing, encouragement, and reminding will help the patient take drugs of correct quantity and doses and at correct time because many patients cannot remember the medication as prescribed by the physician.

đ) Economic burden is one factor that causes discouragement, psychological and physical crisis to the patient and after all affects treatment adherence.

e) Requirement of diet when on ARV Each drug requires different administration relating to diet. Some must be taken right after meals, some long between meals, some others require the abstinence of alcoholic drinks etc., which causes such difficulties to patients as they may forget or stop drinking.

2. Measures to assist the patient with treatment adherence

a) Encourage and assist the patient to have regular check-up at heath care center so that they can always be counseled on the importance of treatment adherence

b) Provide the patient with sufficient in formation about ARV, such as treatment goals, regimen, types of drugs, number if pills, how to take and to keep them, side effects, and prices (if needed).

c) The patient must be fully aware of the importance of treatment adherence, and on that basis assist them to actively develop their treatment adherence plan.

d) Assist the patient to schedule appropriate and proper use of drugs by suggesting daily meal times, when to take drugs according to the meal times.

e) Encourage the patient to talk about barriers to their treatment adherence and help them remove such barriers.

f) For drug and alcohol addicts: help them stop drinking and using drugs, have a stable life, find a treatment observer, and provide them with DOT if possible.

g) Advocate all resources available for free distribution of drugs so as to alleviate the Financial burden for the patient

h) Promote physical and emotional support from their family, friends, and social groups in order to create hope

III. MANAGEMENT OF ADVERSE EFFECTS

Health workers when providing care a patient must have thorough understanding of the ARV drugs that the patient is using; be fully aware of the side effects of each drug, or possible drug interactions (if any), and must be able to explain to the patient so that he/she can identify the side effects or toxicity right after they appear also so that he/she is not too frightened to give up treatment; and also fully teach the patient and their family what they can primarily do at home and when they must refer the patient to health care center or seek professional advice.

1. Vomiting and nausea: often with Zidovudine (ZDV, AZT) or Indinavir (IDV)

- Advise the patient to take the drugs after meals or use antiemetic drugs about between30 minutes and 1 hour before taking the drugs in order to reduce the side effects.
- If this doesn't help, the patient should be assessed by a physician for a more appropriate intervention or changing to another drug.

2. Vomiting or nausea accompanied by abdominal pain, fever:

- Treat the fever, ORS;

- If the fever and pain persists, and the patient vomits a lot: Stop using drugs, refer the patient to health care center immediately, and have amylase test (to see if the patient has pancreatitis due to d4T). If pancreatitis due to d4T is proved, stop using ARV until pancreatitis is treated (replace d4T with AZT).

3. Fever and rash: often occur 1-2 weeks after using Nevirapine (NVP)
- Drink lots of water (especially fruit juices and mineral water);
- Treat high fever with Paracetamol;
- Temporarily stop using all drugs to monitor;
- If the patient gets better, the fever I treated and the rash gradually disappears, after 3 5 days consider using NVP with other drugs in the regimen.
- The patient should be referred to health care center immediately for proper intervention if high fever persists, and the rash spreads out or blisters, necrosis appears.

4.Diarrhea: possible with Nelfinavir (NFV)
- Supplement water and electrolytes: ORS, salted porridge, coconut milk, roasted rice water with salt etc.
- Monitor dehydration through signs, such as thirst, little urination, dry skin, or little tear when a child cries etc.
- Treat diarrhea, for example with loperamid;
- If severe diarrhea persists, the patient should be referred to have dehydration assessed at a health care center.
- At ARV treatment clinic:
- Assessment of dehydration status and consider fluid infusion is needed.
- Consider changing ARVs in the regimen

5. Limb numbness: possible with d4T
- Explanation to the patient is needed so that he/she can be reassured to monitor;
- Mild effects: extra vitamin group B, gentle massaging, NSAID (Ibuprofen)
- If symptoms persist: refer the patient to the physician for assessment and replacement of d4T withAZT.

6. Anaemia: possible with AZT
- If the patient shows to be exhausted, dizzy, pale etc., possibility of anaemia due to AZT should be considered;
- Improve nutrition, supplement iron and protein, vitamin B (especially B12), folic acid
- If the symptom gradually elleviates, continue with regimen containing AZT.
- If the above measures have been taken with no effect, diagnostic tests are needed and often change of AZT with another drug is considered (often with d4T).

7. Kidney stone, hematuria:
Can happen in patients on IDV for long or on IDV but take insufficient water. Sym toms may range from mild level, such as backache or feeling tired in the back to severe level, such a renal colic, microscopic or gross hematuria.
- Explain and en courage the patient to reassure them;
- Let the patient to rest; avoid vigorous movement; and drink a lot of water (boiled corn-silks, plantain); gently massage the pain/ colic area or apply patch on;
- If the symptoms do not relieve, the patient should be referred to the ARV clinic:
- Assessment and proper investigations.
- Treatment may include pain relief, stop bleeding, superinffection prevention etc.,
- Considering changing drugs of the regimen.

8. Night mares, feeling dizzy: often with EFV

- To reduce the symptom, EFV should be taken once at bedtime;
- Reassure the patient so that they can well adhere the treatment;
- If the symptom does not alleviate, but repeatedly happens, consider changing EFV with another drug

9. Jaundice

Jaundice is side effect of some ARVs which may cause hepatitis such as NVP, AZT or ARVs in protease inhibitors (PI).

- When this symptom is noticed, the patient should rest, avoid vigorous movement, and stop using drugs;
- The patient should eat fluid, easy-to-digest food, and avoid fatty and spicy food. Alcoholic drinks are prohibited;
- Monitor the amount and colour of the urine and stool;
- Refer the patient to the health care center for assessment and testing to find out the root causes and appropriate intervention.

10. Severe side effects:

The most severe side effect when on ARV is Steven Johnson syndrome (or Lyell syndrom). All ARV drugs may cause this severe side effect. However, clinical evidence shows that NVP is the one that often causes this side effect. NVP may cause rash red all over the body and the most serious one is Steven Johnson syndrome.

a) Clinical manifestation:

- High fever, feeling chill or shivering;
- Rash then body skin redness;
- Blisters cluster, in the severe cases these blisters are broken;
- Damages in natural hollows: eyes (dropsy red swollen, ulcerative, eye running), nose, mouth and anus. These hollows become dropsy, red and ulcerative;
- Dyspnea may happen;
- Oliguria or anuria;
- Fast pulse, reduced or blocked blood pressure due to dehydration and loss of plasma.

b) Management:

- All patients must be referred to specialized health centre where all equipment, Supplies and medicines are available for treatment;
- Rehyderate and resupply plasma: Saline, Albumin, and Plasma infusion.
- Management of allergy: Coricosteroid intravenous infusion (often with Methyl Prednisolon) together with anti-histamine (Dimedron).
- Antibiotics for superinfection.
- Diuretic and vascular drugs etc., depending on the patient's situation.

c*) Care:* is critical, which affects disease progress.

- Eating: soft, easy to digest and rich in nutrients and vitamins. If the patient can eat, he/she should keep good dental hygiene after meals. If the patient cannot, he/she should be fed through intravenous route or gastric sonde suppository.
- Body hygiene: special care should be provided so as to prevent exfoliation, superinfection: put the patient on soft bed, apply talc powder, broken blisters are cleaned with salt water or hydrogen peroxide, use antiseptic solution (often with Betadin), cover with clean gauze..Antibiotic cream may be applied on the area before covering the gauze to prevent the gauze from sticking to the damaged area. Provide care and hygiene to natural hollows: gargle with antiseptic solutions (such as TB, P/S, salt water 0,9%). Use antiseptic nasal drops such as 0,9%, Chloramphenicol 0,4%. Clean the anus after defecating.
- Avoid bed sore: Reposition the patient to avoid bed sore and superinffection in other organs (particularly lungs and urinary system).

CHAPTER IV
PALLIATIVE CARE FOR CANCER PATIENTS

I. PATIENTS ON RADIATION THERAPY

1. Complications of radiation

a) Local:

- After one week: burning, red mucous membrane
- After 3-4 weeks: red, burnt skin, dry dermatitis, ulcerative mucous membrane.
- With maximum dose: ulceration, membrane necrosis, extensive and limited cutaneous and subcutaneous necrosis.

b) Somatic:

- After one week: hair loss, difficulty in eating, gradual loss of appetite, nausea and vomiting, fatigue, ,inflammation of the bladder. headache, abdominal pain, loose stool, intestinal inflammation
- After 3-4 weeks: anemia, reduced white blood cells.

2. Care for patients on radiation therapy

2.1. Local care

a) Oral care:

- Gargle with 20 time-diluted betadin or slat water many times in a day.
- Brush teeth after meals.

b) Care to radiated skin: No harsh rub, as it may cause scratches and inflammation; Avoid sunshine; use lotion (as prescribed by the physician); provide care to ulcerative burn with salt water of 0,9%, diluted betadin or strong green tea.

c) Other supportive measures:

- Wash the palate and throat to clean necrosis and to prevent superinfection in cancers in head and neck area.
- Douche for radiated cervical and vaginal cancer.
- Care for unhealed incision at post radiated surgery.
- Care for canyl in patient with tracheotomy.
- Enema to patient with pelvic radiation.
- Care for gastric tube.
- Care for artificial anus.

2.2. Entire body care

- The patient should wear loose and soft clothes.
- Clean the body everyday.
- Proper nutrition: soft easy-to-digest food, no stimulants, rich-in-natural-vitamin diet and other micronutrients.
- Analgesics as appropriate to the patient's pain level.
- Antibiotics for superinfection.
- Regular exercise (as appropriate) to avoid connective joint and lymphoedema...

2.3. Psychological care: Thorough and specific explanation; sympathetic and sharing attitudes.

2.4. Cooperate with the patient and family: Teach the patient how to self-care an instruct the family to provide home care.

II. PATIENTS ON CHEMOTHERAPY

1. Complications

- Local care: Leaking of chemicals into subcutaneous tissues during infusion. Feeling of burning pain at the infused area. At mild level there would be blisters, more severe level would cause necrosis of tissues or stripped skin.
- Entire body care: Hair loss, fatigue, nausea and vomiting, diarrhea, anaemia, reduced white blood cells, membrane ulcers, and neuritis, etc.

2. Management

2.1. Locally: manage leaking chemicals

- Stop infusion, lock the drain
- Suck the remaining chemicals there might be leaking
- Draw circle around the suspended traumatic area to monitor.
- Apply cold or warm compress on the trauma.
- In case of burning pain: use external-used lotion, such as: Silvirin, Flammazine.
- In case of necrosis or stripped skin: Change bandage daily with NaCl 0,9% solution, apply burn lotion.
- Explain and reassure the patient.

2.2. Entire body care

- Prevention and management of chemical shock.
- Prevention and management of vomiting:
  + Ondansetron 8 mg/time, maximum 3 times/day, orally or IV; or Metoclopramide 10mg every 4 hours
  + Dexamethasone 8-20mg/day in 1-2 divded doses orally or IV
  + Haloperidol 1-2mg every 4-8 hours orally or IV
  + Mild tranquillizer
- Care to ulcers of digestive membrane (See this section in radiation therapy)
- Reduced white blood cells: use drugs to increase white blood cells, antibiotics
- Anaemia: blood or blood component transfusion
- Pain management
- Proper nutrition

2.3. Psychological care:

- Explain the situation and chemotherapy to the patient and their family (before and after the treatment).
- Teach them how to provide care for chemicals' side effects.
- Encourage the patient to adhere to the treatment schedule.
- Teach them proper diet
- Share their financial worries.

III. CARE FOR PATIENT WITH SURGERY

One characteristic in cancer surgery is that a larger area around the neoplasm is taken together with the lymphonodes, thus the patient is often very weak, has been physically disfigured, and suffers from psychological burden. Each type of surgery requires specific type of care. Essential care may include:

1. Pre-surgical care:

- Fully explain the surgical method, encourage and reassure the patient.
- Careful clinical assessment and perform all necessary tests.
- Improve health status.

- Pre-surgical hygienic preparation: Enema

2. Post-surgical care:

a) Locally (most important within the first 24 hours):

- Change bandage and sterilize with antiseptic solution;
- Care to drainage tubes: make sure they are hermetic, one-way and sterilized. Pull out the tubes instructed by the surgeon: fluid containing bags are hermetic, sterilized and lower than the part of the body where the fluid is drained.
- Open infected wound: care for canyl in patient with tracheotomy, stomach drainage tube, artificial anus, urine drainage
- Watching of post-surgical hemorrhage.

b) Entire body care: Resupply water and electrolytes; antibiotics; suck sputum, supply oxygen if needed; nutrition (be fed after gas passing, soft and loose food for first several days); psychological support (encourage the patient, explore the patient's worries so as to appropriately explain and share with him/her); Move around to avoid stiff joints; Learn to breathe (an exercise to prevent arm lymphoedema after Patey surgery).

CHAPTER V
PEDIATRIC PALLIATIVE CARE

I. DEVELOPMENTAL STAGES

Based on children's development at different stages to understand their needs, understanding of death, and ways of grieving reaction to difficulty or hardship that they undergo.

1. Infants (age 0-1):

- Children do not communicate nonverbally at this age.
- Adults should use simple language, terms, voice and tone that show the love, and touch and caress.
- Need as much consistency as possible in caretakers, setting, and daily routine.
- Will understand and be affected by the (showed) sadness of the parents or caretakers.

2. Toddlers (age 1-3):

- Continue to need as much consistency as possible in caretakers, setting, and daily routine.
- Adults should give simple explanations, be clear and consistent, and prepare the child just before a medical procedure.
- Will be affected by the sadness of the parents or caretakers.
- Have no concept of death.

3. Pre-School Age Children (age 3-6):

- Understand the world by interweaving fact and fantasy ("magical thinking").
- Need as much consistency in daily routine as possible.
- Understand death as reversible: a "temporary departure" or "long sleep".
- Are egocentric and are likely to feel responsibility for their illness and for the sadness or death of a parent. Thus, it is important to explore the child's understanding of the cause of death, correct misconceptions, and dispel guilt.
- When a parent dies, the child may interpret the sadness of the surviving parent or caretaker as disappointment in the child's behavior. Thus, it is important to explain simply that the child is loved and that the parent or caretaker is sad about the death.

4. School-Age Children (age 7-12):

- Thinking is concrete, no abstract reasoning.
- Child begins to understand cause and effect.
- Understand death as irreversible.
- Evaluate for fears of abandonment, destruction, or body mutilation. (need to assess the child's thoughts by inviting the child to share their thoughts, fears, and sadness when he/she is ready)
- Be truthful and open about treatments or about a parent's illness or death without giving too much detail.
- May see treatments as punishments. Thus, reassure the child that treatments are not punishments.
- Wish to understand and control what is happening around. Caregivers should offer choices to give the child a sense of control.
.- After a parent's death may return quickly to their usual activities and to being with best friends. Such activity helps the child to cope with the loss.

5. Adolescents (age 13-16):

- Are capable of abstract thoughts. Cultural specificity begins at this age.

- Undergo dramatic physical change and are very self-conscious.
- Begin to challenge parental values, separate from parents by developing peer-group identity.
- Allow expression of anger.
- Allow privacy and reasonable independence. Maintain access to peers.
- Provide clear, honest, direct explanations.
- May have very complex relationships with and feelings toward both a dying parent and a surviving parent. This may make communication and grieving more difficult. May turn to a non-parental adult to share sadness. It is important for an adolescent to have an adult with whom he/she can remember a dead parent, whether that adult is the surviving parent or another adult.
- Is at risk for developing depression. Signs may include guilt feelings, suicidal ideation. Depression requires treatment.

II. SYMPTOM ASSESSMENT

a) Begin with direct observation of the child and reports from parents or other adult caregivers.
- Notice body position, spontaneous movements, level of arousal, and interaction with others.
- In preverbal children, pain or nausea can be indicated by crying, Irritability, withdrawn or depressed affect, tense body position facial grimacing, or fearfulness.

b) Ask (even very young) children if and where they hurt before trying to examine them. Can use "Wong-Baker Faces Scale" or the 0-10 scale to assess pain.

c) Physical examination, or even anticipation of physical examination, can cause a child to start crying. Once the child is frightened and crying, it is difficult or impossible to determine areas of tenderness and to complete the physical exam. to reduce the child's fear, ask him/her to tell you as soon as something hurts.

d) Neuropathic pain may have associated motor or sensory changes.

III. MANAGEMENT OF SOME END-OF-LIFE SYMPTOMS

Symptom	Palliative medications (select appropriate drugs for treatment decision)	Dosage and Administration
Pain	See pain management (Chapter II, Item I)	
Dyspnea	Morphine sulfat orally or Morphine clohydrat IV	0.1 mg/kg orally (immediate release) or 0.05 mg/kg SC/ IV every 2-4 hours as needed.
	Lorazepam	0.025-0.1 mg/kg orally/SC/IV every 2-4 hours as needed
Constipation	Children's Senekot liquid	2-6 years: 2.5-3.75 ml once per day 6-12 years: 5-7.5 ml once per day
	Glycerin suppository	1 suppository per rectum once per day
	Sorbitol	5-10 ml orally every two hours until stools
	Pediatric Fleets enema	Once per day as needed
Diarrhea	Loperamide	13 - 20 kg: 1mg three times per day orally as needed. 20 - 30 kg: 2mg two times per day orally as needed. > 30 kg: 2mg three times per day orally as needed.
Nausea / vomiting	Diphenhydramine	1 mg/kg orally/IV every 6 hours as needed
	Metoclopramide	0.25 mg/kg orally every 8 hours as needed
	Ondansetron	0.15 mg/kg orally every 8 hours as needed
	Scopolamine	Adolescents: 1.5 mg by transdermal patch every 72 hours
	Lorazepam	0.025-0.1 mg/kg orally/IV every 8 hours as needed
Fever	Paracetamol	15 mg/kg orally/ perrectum every 4 hours as needed
	Choline magnesium trisalicylate	25 mg/kg orally 3 times per rectum day as needed
	Ibuprofen	10 mg/kg orally every 6-8 hours as needed
Sweats	Cimetidine	20-40 mg/kg/day orally in divided doses every 8 hours
Insomnia	Lorazepam	0.025-0.1 mg/kg orally/SC/IV at bedtime
	Amitryptyline	Begin with 0.3 mg/kg orally at bedtime
Fatigue/weakness (At the end stage, when specific treatments are effective)	Prednisolone	1 mg/kg once or twice per day orally with food
"Death Rattle"	Hyoscamine sulfate	If needed: Age < 2 years: 4 drops every 4 hours orally as needed(0.125mg/ml). Age > 2-12: 8 drops every 4 hours (0.125mg/ml).

IV. BEREAVEMENT IN CHILDREN

1. It is important for grieving children to continue age-appropriate activities. Family time and daily routines should be protected (if possible).
2. Children should be encouraged to tell a trusted adult everything they hear about the parent's illness or death. It is important to be honest with children without overwhelming them. In general, children's questions should always be welcomed.
3. Memory items (boxes, books, gifts from parents) help children to maintain a spiritual connection to their dead parent. Such memory items can help a child to grieve, to make sense of the loss, and to develop and maintain a sense of identity and roots. They can include photos, letters, family stories, diaries, tape or video recordings, souvenirs

CHAPTER VI
END-OF-LIFE CARE

Once medical interventions do not work to save the patient's life, care will be shifted to assisting the patient to have a comfortable and peaceful death. In addition to relieving pain and other symptoms, end-of-life care may include emotional, spiritual, and psychological support, nursing care for the sick person, the family and the caregivers.

I. EMOTIONAL AND SPIRITUAL SUPPORT

1. Be present to comfort the patient to help them feel that they are cared but not left alone.
2. Encourage the patient to talk about their feelings, wishes and help them with unfinished tasks.
3. Listen attentively and be empathetic: some AIDS patients may experience feelings of guilt as they have infected their partners or brought shame to the family, and thus they seek forgiveness. Caregivers should encourage and show their empathy to the patient.
4. Respect the decision of the patient as per where they want to be cared by the end of their life, which might be at medical setting or at home.
5. It is not advisable to create false hope in the patient, but only set minor goals in the family future.
6. Spiritual support: Caregivers should recognize the patient's needs for religious support, and respect their religious values and beliefs, including the patient's wish about how the funeral should be proceeded.
7. Keep calm and absorb the patient's anger.

II. RELIEVE PAIN

Pain suffered by cancer and AIDS patients is not appropriately diagnosed and treated, thus one of very important tasks of end-of-life care is to alleviate pain for the patient. Following are some instructions:

1. Respect the patient's complaint of pain, do not rely on subjective evaluation of health care workers or caregivers.
2. Use pain control measures, such as massaging or warm compress etc.,to minimize suffering from pain for the patient and comfort their worries.
3. Use analgesics around the clock, day as night. It shouldn't be hesitated to use such efficacious analgesic for the patient at last stage.
4. Drugs are taken through the most simple route to prevent the patient from pain suffering: oral administration is most recommended or subcutaneous injection (SC) intramuscular injection (IM) is not as efficacious or fentanyl transdermal patch (durogesic).
5. If the patient is discharged back home, family should be taught how to provide care, especially how to use correct doses of analgesics at correct times.

III. NURSING CARE

1. Nutrition: Offer small amounts of soft food like soup, porridge, do not force the patient to eat; encourage the patient to take water or fruit juices.
2. Body hygiene: Provide regular bathing or cleaning the body, keep the anal and genital area clean and dry; provide oral hygiene and clean eyes.
3. Skin and membrane care: Keep the skin clean and dry, use bandage in case of skin inflammation, ulcers or infection.
4. Repositioning: Assist the patient to sit up or on a chair if possible. When in bed, change the patient's position frequently and keep in comfortable position.
5. Respiratory care: Help the patient to sit up if feel difficult to breath, provide oxygen and

suction sputum as needed.
6. Care when patient gets confused: When the patient gradually loses memory, cannot talk clearly nor recognize things around, caregiver should be present to look after and help him/her avoid dangers.
7. Cooperate with the family: Remain contacted with the family about the patient's health status, when the patient is near death, inform the family and loved ones to come to say goodbye if they wish.

IV. DYING AND BEREAVEMENT CARE

1. Signs of imminent death

- Sleeps more or coma;
- Acts confused;
- Decreased food and fluid intake (no hunger or thirst);
- Reduced urine and bowel movements;
- Respiratory changes (fast, irregular breathing);
- Circulatory changes (increased heart rate, decreased blood pressure, could extremities).

2. Signs of death

- Breathing stops completely;
- Heart beat and pulse stop;
- Totally unresponsive to shaking or shouting;
- Eyes fixed in one direction, eye lids open or closed;
- Changes in skin tone.

3. Bereavement care

- Caregiver wear clean gloves
- Close the patient's eyes and keep for several seconds;
- Help close his/ her mouth;
- Put away drain and band in the body (if any);
- Clean any discharge on the body;
- Put away any device from the bed;
- Change clothes;
- Lay the body neat on the back, two arms stretched down along the body;
- Place a small pillow under the head;
- Comfort and share with the family;
- If the patient passes away in hospital, proceed as hospital regulations. If the patient passes away at home, do not let discharge from the body contact directly with hands of caregiver.
- Burial as local custom and as the family wishes.

CHAPTER VII
ANNEXES

ANNEX 1
LIST OF ANALGESICS IN PALLIATIVE CARE AND COMMON BRANDED DRUGS

Note: Branded names are for reference only

No	Drugs, Active ingredients	Branded names	Contents, Route of Administration	Category
A. Non opioids				
1	Paracetamol	Dafalgan	PO; powder package 80mg, 150mg, 250mg	Over the counter
		Efferangan Dopalogan	PO; tablet100mg, 500mg Suppository; 80mg, 150mg, 300mg, 600mg	
		Perfangan	IV; 0,3g, 0,45g, 0,5g, 1g/100ml	
	Paracetamol + chlorphenamine	Panadol, pandol, zandol	PO; tablet 325mg + 4mg	Over the counter
	Paracetamol + ibuprofen	Alaxan	PO; tablet 325mg + 200mg	Over the counter
2	Ibuprofen	Mofen 400, motrin, Gelufen	PO; tablet 200mg, 400mg	Over the counter
3	Choline magnesium trisalicilate D			
4	Diclofenac	Voltaren	Injection; 75mg/3ml	Over the counter
			PO; tablet 25mg, 50mg, 75mg, 100mg	
5	Diflunisal		DO: table 250mg, 500mg	Over the counter
6	Etodolac	Tebret	DO: table 400mg	Over the counter
7	Fenoprofen		DO: table 300mg, 600mg	Over the counter
8	Ketoprofen	Ketopen, Ketum,	Injection; 100mg	Over the counter
		Ketoridis, Ketocid	PO; tablet 50mg, 150mg, 200mg, 250mg, 500mg	
9	Ketorolac	Nodine	Injection; 30mg	Over the counter
10	Meloxicam	Itermecicam, Medaxicam,	Injection; 15mg	Poison schedule B
			PO; tablet 7,5mg, 15mg	

		Mel-ol, Melobic, Mobic, Melgesic, Melogisic, Melonex-7,5/ Melonex-15		
11	Piroxicam	Pirocam	Injection; 20mg/ml	Poison schedule B
B. Opioid-alike analgesics				
12	Tramadol	Tramadol Stada	Injection; 50mg, 100mg PO; tablet50mg, 100mg PO; syrup 2000mg/20mg	Narcotic
C. Mild Opioids				
13	Codein		Tablet 10mg, 30mg injection; 50mcg/ml	
	Codein phosphate	Efferangan codein	PO; tablet30mg + 500mg	Over the counter
14	Dextropropo xyphen	Proxyvon	PO; tablet50mg, 100mg, 150mg	Addictive
	Dextropropo xyphen + Paracetamol	Di-altanvic Dodatalvic	PO; tablet65mg + 500mg	Over the counter
D. Strong Opioids				
15	Morphine (sulfate)	PO; tablet10mg, 30mg		Narcotic
	Morphine (clohydrate)	Injection; 10mg/1mg		
16	Oxycodone		PO; supension 1mg/ml, 10mg/ml	Narcotic
	Oxycontine		PO; tablet 5mg, 10mg, 20mg, suppository 30mg	Narcotic
17	Hydromorphone		PO; tablet 2mg, 4mg, 8mg PO; suspension 1mg/ml Infection; 2mg/ml, 10 mg/ml	Narcotic
18	Fentanyl	Duragesic	Transdermal patch	
			Injection; 0,05mg/1ml, 0,1mg/1ml	Narcotic

ANNEX 2
MANAGEMENT OF OPIOID MEDICATIONS

- Opioids are used in palliative care for cancer and AIDS patients.
- Based on the implementation guidance: (1) Decision No. 1847/2003/QĐ-BYT May 28, 2003 of the Health Minister on Regulations on Prescription and Selling Prescribed drugs; (2) Decision No. 2033/1999/QĐ-BYT July 09, 1999 of the Health Minister on Regulations on Narcotic Management, List of Narcotic and Combined Medications.
- Offices, units, individuals manage and use narcotic are responsible for supplying enough drugs to meet treatment needs of in- and out- patients, ensure rational and safe use of drugs who are in need of palliative care as existing rules and regulations.

1. Provincial Department of Health

a) Instruct health care facilities under its supervision to dispense and transfer opioids to serve in-patients.

b) Instruct drug pharmacies to organize opioid selling to serve outpatient use as prescribed by doctors.

2. Health care institutions (hospitals, institutes with patient beds, policlinics)

a) All these institutions use opiates for patients who need palliative care according to specialization and technical level regulated by the Ministry of Health (MoH).
b) Physicians who are allowed to prescribe opiates must have their signatures registered with competentpharmacies todispense opiates.
c) For patient who have been referred to lower level of treatment or for home care, there must be a cooperation to monitor the use of opiates.

3. Health care workers

a) Physicians prescribe opiates according to current Stipulation on Prescription and Dispensary of Prescription Drugs. Specifically, it is not allowed to prescribe longer than: 7 days for opioids. For morphine clohydrat 10mg/1ml tube, not longer than 5 days for cancer patients requiring more than 30 mg per day.
b) Clinically needed given the above duration, the physician can still prescribe opiates as per clinical requirement of the patient, but ensures the safety for the patient.
c) In the case that the out-patient was indicated with opioids by provincial health care institutions/ specialized hopspitals, used up all prescribed opioids, but can not go back to provincial health care, but can go to district health centres/district hospitals, after consultation, the physician, seeing the need of continued use of opiates, can prescribe as per their specialization and current regulation.

4. Communal health Stations

Communal health clinics are responsible for use of opiates in palliative care:
a) Implement the opioid indications by the physician in the community.
b) Monitor the use of opiates by the patient.
c) In case the opiates prescribed are not available for the patient, the Commune health Center can provide medical check-up and indicates use of opiates as emergency case in order to make sure that the patient has analgesics for pain relief.
d) In the case the patient has used up opioids, but yet to have the next prescription for opioids, the Commune Health Center can give morphine (listed in essential drugs allowed to use at

commune health center) as in pain in that situation is considered as emergency, then refer to higher level of treatment.

e) In the case that the patient does not use up the opioids, Commune Health Center makes a report to take the opiates back, and then reports to District Health Bureau to: be added to the emergency drugs stock (if drugs left have clear sources of distribution, are of good quality and appropriate to specialized and technical requirements), or can be disposed of with the presence of agencies as regulated.

5. For patients using opiates

a) The prescription is valid within 10 days from the date of prescribing

b) Use as indicated

c) Do not use for any other purpose; do not trade or give the drugs to any other.

d) The patient and/ or their family is responsible for notifying the Communal Health Center about the use of prescribed opioids.

e) If the patient dies at home, family members are responsible to inform the Commune Health Center.

6. Commitment of using opioids:

May refer to this sample when in need. "The commitment of using opiods" should include regulations for users as follows:

a) Only use the opioids as indicated.

b) Do not seek for drugs from any other sources.

c) Only receive opioid analgesics at scheduled examinations but not any other prescription of opioids except when the patient has to come back for re- examination because the pain gets worse. Reports of loss or theft of opioids are not accepted except only when the police have been notified.

d) The patient must be ready for drug tests whenever required.

e) Never illegally use drugs or sell prescribed opioids.

f) Any violation of this commitment may result in termination of opioid treatment.

ANNEX 3
BRIEF PAIN INVENTORY

Date: ☐☐/☐☐/☐☐ (date) (month) (year)

Study Title: (used when needed) .....

Patient's name:

Study Code: (used when needed) ☐☐☐☐

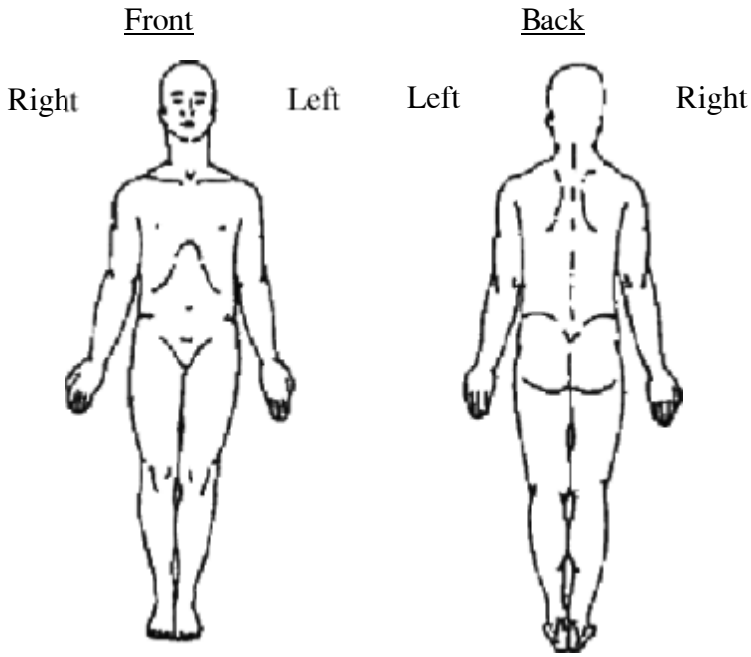
Study Number: (used when needed)

Brief Pain Inventory

1. Throughout our live, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by ticking the one box that best describes your pain at its worst in the past 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No pain — Pain as much as you can imagine

4. Please rate your pain byticking the one box that best describes your pain at its least in the past 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No pain — Pain as much as you can imagine

5. Please rate your pain by ticking the one box that best describes your pain on the average

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No pain — Pain as much as you can imagine

6. Please rate your pain by ticking the one box that tells how much pain you have right now

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No pain — Pain as much as you can imagine

7. What treatments or medications are you receiving for your pain?

.....

8. In the past 24 hours, how much relief have pain treatments or medication provided? Please tick the one box that show how much relief you have received.

0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐

No relief — Complete relief

9. Tick the one box that shows how much pain, in the last 24 hours, has interfered with your:

A. General activity

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does not interfere — Completely interferes

B. Mood

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does not interfere — Completely interferes

C. Walking ability

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does not interfere — Completely interferes

D. Normal work (including work outside the home and housework)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does not interfere — Completely interferes

E. Relations with other people

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does not interfere — Completely interferes

F. Enjoyment of life

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does not interfere — Completely interferes

ANNEX 4
PSYCHOSOCIAL ASSESSMENT

1. Mental Health: Mark ☐ (if applicable to patient concerns) Client

Needs/Comments: _____

_____

Any mental health-related hospitalizations? No ☐ Yes ☐

Risk assessment (if above warrants - important to be direct)

Have you ever thought of harming yourself or others? ☐ No ☐ Yes (details if yes)

_____

_____

Substance and/or alcohol use: Mark ☐ (if applicable to patient)

Do you currently routinely use any substances? ☐ No ☐ Yes (specify type):

_____

In the past, did you ever routinely use substances? ☐ No ☐ Yes

What did you use? _____ When was the last time you used?

_____

Have you ever overdosed? ☐ No ☐ Yes When? _____ What from? _____

2. Sleep: Mark ☐ if applicable to patient

Sleep patterns: _____ Number of hours: _____

☐ restful ☐ naps ☐ restless ☐ fatigue ☐ insomnia ☐ night sweats ☐ sleep walking

Use sleeping pills? _____ Other method to improve sleep? (Specify)

_____

Preferred location for sleep: _____

Client Needs/Comments: _____

3. Complementary Therapy / Alternative Medicine Mark ☐ (if applicable to patient)

Complementary therapies and Alternative medicine presently used: ☐ No ☐ Yes

Client Needs/Comments: _____

4. Spiritual Assessment: Mark ☐ (if applicable to patient)

Any religious/spiritual practices we should be aware of? ☐ No ☐ Yes

Any cultural customs/practices we should be aware of? ☐ No ☐ Yes
Client Needs/Comments: _____ Who do you turn to

For spiritual guidance and support? _____

_____

Client Needs/Comments: _____

If the Client expresses need for spiritual support, refer to appropriate service (e.g. local pagoda, church)

5. Coping and Support Systems: Mark ☐ (if applicable to patient)

What do you do to help cope with your illness and related issues? _____

_____

How have you managed in the past? _____

_____

Counseling Needs? ☐ No ☐ Yes (specify) _____

_____

_____

Who do you count on for support?

Have you told family/partner or friends about your illness, treatment? No☐ Yes☐

Comment: _____

What is your family's/partners understanding of your illness? _____

_____

Do you want help in disclosing your diseases to your family/partners? No☐ Yes☐

Comment: _____

6. Main concerns of the patient and family/partner:

Caregiver support needs (i.e. home-based care team, respite, etc.) _____

_____

Any home-based care/volunteer support needs?☐ No☐ Yes

Comments: _____

_____

Are there young children in this situation that may require support services during

this illness?☐ No☐ Yes

Comments: _____

_____

7. Intimacy Mark ☐ (if applicable to patient)

Intimacy is still needed throughout life especially when you are ill.

Has your illness affected your sense of intimacy with others? No Yes

Client Needs/Comments: _____

_____

Are you concerned about your relationships? ☐No ☐Yes

Client Needs/Comments: _____

_____

Other Needs/Comments: _____

ANNEX 5
INFECTION PREVENTION WHEN CARING FOR HIV/AIDS PATIENTS AT HOME AND IN THE COMMUNITY

1. Important notes

- HIV is present in blood and blood-containing fluids, vaginal discharge, semen pericardium fluid, cerebrospinal fluid, articular membrane fluid, amniotic flui.
- HIV is not present in tears, sweat, feces, urine, saliva, nasal mucous, vomiting without blood.
- Blood and body discharge must be considered to contain pathogens of Hepatitis B & C and HIV.
- Risk of HIV/ AIDS infection to caregivers is very low when univesal preccautions are taken.

2. Infection control measures for care givers

2.1 Washing hands with water and soap

Wash hands:

- Before preparing food
- Before providing care or helping the patient to take medications
- After contact with the patient's blood or body fluids
- After taking off gloves
- After going to toilet

Routine hand washing procedures:

- *Step 1:* Thoroughly put water and washing liquid on the hands.
- S*tep 2:* Wash the palms and between-the fingers, put two palms against each other in a way that each finger of the one hand is between those of the other, rub two hands along the fingers 5 times.
- *Step 3:* Wash the back of the hands and between-the fingers, put the palm of one hand on the back of the other in a way that each finger of the one hand is between those of the other, rub along the fingers 5 times, then change and repeat.
- *Step 4:* Wash the thumbs, keep one palm around the thumb of the other hand, turn around the thumb forward and backward 5 times, then change for the other
- *Step 5:* Wash the finger tips, Keep 5 tips together on the palm of the other, turn and rub against the palm 5 times and change for the other.
- *Step 6:* Dry hands, absorb the water with a clean towel and let them dry.

2.2. Putting on gloves

- Gloves help prevent micro-organism from transferring to the skin of the caregiver.
- Gloves should be worn whenever contact is possible with the patient's blood or potentially infectious body fluids and whenever the skin of the caregiver is not intact. For other care which

does not require contact with the patient's blood or body fluids, the caregiver does not need to use gloves.

- After taking off the gloves: Wash hands with soap.

2.3. Providing care to damaged skin: all open wounds of the patient or caregiver must be covered with bandage.

2.4. Cleaning blood stains and body discharge: When there are blood stains or body discharge on the floor or household items, gloves must be used and clean the stains with a piece of cloth soaked with soap/ bleach. Thoroughly wash all cleaning tools and wash hands immediately after taking off the gloves.

2.5. Linen: When the patients clothing is stained with blood, feces, or other bodily discharge, the clothes must be separated from that of the others in the family and washed with daily bleach solution. Process linens from HIV/AIDS patients similarly to blood or body fluid contaminated items of patients with other diseases.

2.6. Use of daily items: Do not share daily used items which can scratch or break skin or membrane, such as tooth brushes, razors, needle, or other sharp items.

2.7. Disposal of waste: All waste stained with blood, or body fluids must be kept in intact and tightly tied plastic bags, which are then placed in bins with covers. The waste should be kept away from animals, children and other people. At medical settings, disposal of waste must follow procedures as regulated by MoH.

ANNEX 6
TRADITIONAL MEDECINE IN PALLIATIVE CARE

- Depend on each patient's condition to select traditional medicine palliative care alone orcombine with western medicine to provide care for patients with cancers or HIV
- Attention for massaging and acupressure:
- In patient with skin ulcer, do not massage and acupressure in this lesion areas.
- When massaging for patient who has itching or lesion in skin, wear gloves and follow infection prevention
- Select appropriate actions for patients.
- Be careful when use acupuncture for patient with HIV because of HIV infection.

1. Pain
1.1. Headaches
a. Massaging and acupressure

Performance: Let the patient sit up or lie down, massage in the following order:

- Pressing: press the thumbs from between the eyebrows towards the sides and down to the temporal bones.
- Pinching: pinch between the eyebrows (Ấn Đường spot) to the both sides about 2 -3 times.
- Spot pressing: gently press and turn the thumbs on the top of the head and other aching spots on the head.
- Patting: use the hands to pat around the head twice in opposite directions.
- Chopping: use the technique to chop the fingers around the head.
- Palm pressing: use two palms to press the head upwards.
- Combing: use fingers to comb the hair downwards.
- Turning head: the physician stands behind the patient, use one hand to keep the chin, put the other on the upper back part of the head. Gently turn the head to the right and left, speed until the muscles become soft, carefully turn the head to the right or left from the front to the back with one quick movement. Repeat with the other side.

b. Acupuncture

- *Accupuncture:* on Ấn đường, Duong bạch, Thái duong, Bách hội, Phong trì. Once a day, 15-20 min each time.
- *Magnetic accupuncture:* Apply magnetic patches on head spots, such as Ấn đường, Duong bạch, Thái duong, Bách hội, Phong trì. Take them of after about 5 days. When having bath, take the magnets and the tape off and reapply them after bath. Keep the magnets dry.

1.2. Pains in back of the neck, shoulders and limbs
a. Massaging and acupressure: Let the patient sit up, perform in the following order:

- Use the part of the palm below the thumb to gently massage the back of the neck.
- Sliding: use the back of the fingers to slide on the back of the neck and shoulders.
- Use the fingers to press the back of the neck and the shoulders.
- Acupressing: find the worst painful spot, press gently and then hard. After that press the spots: Phong phủ, Phế du, Phong trì, and Thiên tông.
- Turning head: See this part for headaches above.

b. Accupuncture:

- Accupuncture:
    + On Phong trì, Phong phủ, Kiên tỉnh, Đại truỳ, Kiên ngung
    + Pick toward the right direction, once a day, 15-20 min each time
    + More effective if combined with massage and acupressing

- *Magnetic accupuncture:* Apply magnetic patches on head spots, such as Phong trì, Kiên tỉnh, Tý nhu, Kiên ngung. Take them of after about 5 days. When having bath, take the magnets

and the tape off and reapply them after bath. Keep the magnets dry.
c. Medicines

1.3 Pain in the upper limbs: Let the patient sit up, perform in the following order:
- Press the shoulders.
- Slide the shoulders.
- Use fingers to press the arms.
- Acupressing: find the worst painful spot, press gently and then hard. After that press the spots: Kiên tỉnh, Kiên ngung, Thiên tông, Thủ tam lý, and Hợp cốc.
- Move the joints of the shoulders, elbows, wrists.

1.4 Pain in the lower limbs: Let the patient lie on the back, perform in the following order:
- Press the thighs and legs.
- Slide the leg.
- Press the feet.
- Acupressing: find the worst painful spot, press gently and then hard. After that press the spots: Phục thỏ, Tất nhãn, Túc tam lý, Duong lăng tuyền, Giải khê.
- Move the joints of the toes, knees and thighs.

Let the patient lie face down, perform in the following order:
- Massage the waist.
- Press the buttock and legs.
- Slide along the back of the legs.
- Acupressing: find the worst painful spot, press gently and then hard. After that press the spots: Hoàn khiêu, Ủy trung, Thừa son, Côn lôn.
- Move the joints of the toes, knees and thighs.

b. Magnetic acupuncture:
- Pain in back of the neck: Apply magnetic patches on head spots, such as Phong trì,
- Kiên Tỉnh, Tý nhu, Kiên ngung. Take them of after about 5 days. When having bath, take the magnets and the tape off and reapply them after bath. Keep the magnets dry
- Pain in the upper limbs: Apply magnetic patches on the spots: Phong trì, Kiên tỉnh,
- Kiên ngung, Thuỷ tam lý, and Hợp cốc.
- Pain in the lower limbs: Apply magnetic patches on the spots: Hoàn khiêu, ủy trung, Thừa sơn, Côn lôn, Túc tam lý, and Dương lăng tuyền.

c. Traditional drugs: (Massaging)
- 100g of mugwort roasted with salt, wrap in a piece of cloth and compress on the pain.
- Remedy (3-308): 12g of the part above the ground of Hy thiệm (cỏ di) boiled in 500ml until about 200ml of the water left then drink in twice a day.
- Remedy (2-52): 16g of the roots of the betel, 12g of the roots of lá lốt, and 12g of momordica boiled in 300ml of water until 200ml left, then drink in twice a day.

1.5. Pains in joints
- Remedy for pain and numbness in the joints without being red or swollen: 40g of Roasted Ý dĩ nuts boiled in 500ml of water until about 300ml left, use for drinks instead of tea in 2-3 times per day.
- Remedy for red swollen joint pain:

+ Sliced and roasted Dâu đau xương dipped in rice brandy with the proportion of 1/5, drink 20ml three times per days for 7-10 days.
+ Or use Hy thiêm remedy as above.

1.6. Chest pain
a. Acupressure: Let the patient lie on the back, massage in the following procedure:
- Press and move from the chest out to both sides: place the fingers between rips numbers 1, 2,

and 3, then press out along the rips 3-4 times.
- Dividing chest: place the part of the palm below the last fingers along the breastbone, slide down to the end of the breastbone and out to the both sides 5-10 times (avoid touching the breasts of a woman).
- Acupressing: find the worst painful spot, press gently and then hard. After that press the spots: Đản trung, Chương môn.

b. Magnetic acupuncture: Apply magnets on the spots: Đản trung, Chương môn, and Hợp cốc.

c. Traditional drugs:

Remedy for dypsnea, chest pain and coughing: Thạch xương bồ đề (roots or leaves): 20g, dry onions: 12g, ginger: 20g, fresh mugwort: 20g. Smash all together, roast to make it hot then compress the chest and back (top down).

1.7. Pain and tiredness on the back

a. Acupressing: Let the patient lie face down, perform as follows:
- Press then gently pat the two parts along the spine.
- Acupressing: find the worst painful spot, press gently and then hard. After that press t h e spots: Đại chữ, Phế du, Đại trường du.
- Slide the two parts along the spine.
- Move the spine around.

b. Magnetic acupuncture: Apply the magnets on the spots: Đại trữ, Phế du, Thận du, and Đại trường du.

c. Drugs: The same remedy as for pain in the limbs, may use together with some kidney fortifying products sold in the market. Use as prescribed.

1.8. Stress: Qi Gong is on exercise to adjust any body imbalance, which help reduce all psycho stress, maintain health and prevent diseases. Qi Gong can be exercised in two positions, statically and dynamically, and in three areas: moving, breathing, and thinking.
- A basic Qi Gong proceeds through 7 steps:
  - Step 1: breathe the air in.
  - Step 2: lead the air into the pulse.
  - Step 3: activate the air.
  - Step 4: lead the air to targeted/sick areas.
  - Step 5: self massage.
  - Step 6: self acupress.
  - Step 7: lead the air to normal status.
- Do the exercise once or twice daily.
- Duration 45 minutes each.
- The exercise should be done early in the morning and before bedtime.

2. Management of common symptoms

2.1. Oral ulcers

- Remedy 1: Boil 1000g of sliced betel leaves in 2 litres of water until it turns condensed, use cotton buds to apply on the ulcers 3-4 times per day.
- Remedy 2: Boil 20g of honeysuckle flowers (hoa kim ngân) with 20g of liquorice in 2 litres of water, gargle the decoction 4-6 times per day

2.2. Nausea and vomiting

- Remedy 1: Boil 8g of fresh ginger in 500ml of water for 5 minutes for daily drinks.
- Remedy 2: Mix 200mg of sugar cane juice with 25ml of 10% ginger juice, slip the mixture in a day.
- Remedy 3: Boil 8g of alpinia root (củ riềng) with one Chinese jujube (táo tàu) in 300ml of

water until 100ml left, drink in 2-3 times a day.

2.3. Weight loss, fatigue, body wasting

- Remedy 1: (used for fatigue). Boil 6g of the root of cây Đinh lăng (more than 3 years old) in 100ml of water for 15 minutes for drinks in 2-3 times a day.
- Remedy 2: (Weight loss, fatigue, lack of appetite, dyspepsia). Boil 16g of oppositifolius yam, 16g of lotus seeds, 16g of broad beans (đậu ván trắng), 8g of job's tears (bo bo ý di), 8g of malt (mạch nha), 8g of medlar (son tra) in 500ml of water until about 200ml left for drinks in 2-3 times a day.
- Remedy 3: (Weight loss, fatigue, skinny, chronic dry cough, hot inside)
- Boil 16g of oppositifolius yam (củ mài), 8g of malt (mạch nha), 12g of thiên môn, 12g of mạch môn, 12g of the root peel of mulberry (cây dâu) in 500ml of water until about 200ml left for daily drinks.
- Remedy 4: (Fatigue, lack of appetite, weight loss). Make porridge of 20g of oppositifolius yam (củ mài), 10g of the inner membrane of chicken gizzard, which has been cleaned, dried, and roasted to become yellow (màng trong của mề gà) with 150g of rice.

2.4. Diarrhea

- Remedy 1: Boil 12g of guava buds, 8g of vỏ thân ối, 8g of sapan-wood (tô mộc), 2g of fresh ginger in 200ml of water until about 100ml left for drinks in 4-5 times per day
- Remedy 2: Smash 30g of pennywort (both the stems and leaves), put some sugar into the juice for daily drinks or use the pennywort instead of vegetables.
- Remedy 3: Berberin capsules of 100mg each, orally two capsules per day.

2.5. Ulcers

- **Management of skin ulcers**
  + Wound cleansing solution: Boil 40g of betel leaves in 2 litres of water for 15 minutes. Let it cool down then add alum (phèn phi) to clear then use the solution to cleanse wounds.
  + Dressing drugs are to cleanse the wound, necrosis, and to develop new skin
- **Remedy:**
  + Leaves of mỏ quạ, lygodium leaves (lá bòng bong), lá ban/nọc sởi (bauhinia leaves) of similar amount. Smash altogether, take the veins of the leaves out, then Apply directly (or on a gauze) on the ulcers, change the bandage every 2-3 days.
  + Or heat it into jelly (or use Mỏ quạ jelly which is produced by the Institute of Traditional Medicine)
- **Oral remedy:** Boil 10g of móng tay leaves, 12g of mugwort (ngải cứu), 12g of huyết giác, 10g of turmeric (nghệ), 10g of sapan-wood (tô mộc), 1 decoction per day.

2.6. Fever

- Remedy 1 (Fever without sweat): Boil 20g of basil (húng quế) in 200ml of water, drink while hot, then cover with blanket to promote sweat.
- Remedy 2 (Fever, sore throat and cough): Boil 20g of kudzu root củ sắn dây),10g of mulberry leaves (lá dâu), 15g of majoram leaves (lá kinh giới), 15g of liquorice (cam thảo dây), 6g of mint leaves, 4g of cúc hoa vàng in 300ml of water until about 100ml left for drinks in twice a day.
- Remedy 3 (high fever, sweat, dry mouth, thristy): Boil 15g of alang grass roots (rễ cỏ tranh), 15g of bamboo leaves, 20g of pennywort leaves, 15g of lá dấp cá, 15g of liquorice (cam thảo nam) in three bowls of water until about 1 bowl left for drinks in twice a day.

2.7. Cough

- Remedy 1 (dry cough): 3-4 wampee fruits (qủa hồng bì), 2-3 kumquats with honey or sugar of appropriate amount. Steam all or put in a rice pot for 15 minutes, use daily.

- Remedy 2 (dry cough): Boil 16g of mạch môn roots, 16g of thiên môn, roasted peels of mulberry roots soaked with honey (vỏ rễ dâu tẩm mật ong sao thom), 6g of liquorice in 600ml of water until 200ml left for drinks in 2-3 times per day.
- Remedy 3 (cough and eliminating sputum) Roast 20g of plantain seeds (hạt mã đề), 10g of white radish seeds (hạt cải củ), 10g of perilla, and 4g of cải canh seeds, then boil in 400ml of water for 30 minutes, add some sugar then drink in 3 times per day
- Remedy 4 (Cough with sputum and fever) Ma Hanh jelly (produced by the Institute of Traditional Medicines). Used as per instruction.
- Remedy 5 (Cough with lots of sputum): Use Bổ phế chỉ khái lộ (lung fortifying syrup) produced by Ha Nam Pharmaceutical Company. Use as per instruction.

2.8. Dyspnea
- Remedy 1 (Dyspnea, chest pain and cough): 8g of liquorice, 40g of honey, 10 drops of alcohol vinegar. Boil the liquorice add honey and vinegar then mix to drink.
- Remedy 2: 100g of marjoram flowers (hoa kinh giới) roasted till burnt, 1000ml of alcohol vinegar. Smash the roasted marjoram flowers, mix with vinegar then use a piece of cloth soaked with the mixture and rub on the itching areas.
- Remedy 3: Boil 10g of honeysuckle (hoa kim ngân) with 4g of cockleburr in 200ml of water until 100ml left for drinks in twice a day.

2.9. Itching
- Remedy 1: Smash to get juice from fresh starfruit leaves then use to bathe or apply on the itching areas.
- Remedy 2: 100g of marjoram flowers (hoa kinh giới) roasted till burnt, 1000ml of alcohol vinegar. Smash the roasted marjoram flowers, mix with vinegar then use a piece of cloth soaked with the mixture and rub on the itching areas.
- Remedy 3: Boil 10g of honeysuckle (hoa kim ngân) with 4g of cockleburr in 200ml of water until 100ml left for drinks in twice a day.

2.10. Insomnia
- Remedy 1: put 10g of dried lotus pistils (nhị sen) in 100ml of boiling water and drink instead of tea.
- Remedy 2: Boil 150g of passion-flower leaves (lá lạc tiên), 100g of vông nem leaves, 12g of dried longan in 500ml of water until 250ml left for drinks in twice daily, at lunchtime and before bedtime.
- Remedy 3: 100g of pergularia flowers (hoa thiên lý) coked as vegetables for daily consumption.
- Remedy 4: 100g of fresh lotus rootstocks (or 25g of dried lotus rootstock powder), 50g of rice, 10g of sugar. Cook rice porridge, add powdered lotus rootstock and sugar when the porridge is ready, mix well before serving. If fresh lotus rootstock is used, wash it and slice then put into the porridge. (Lotus rootstock porridge).

2.11. Anxiety depression: Exercise and meditation.

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VICE-HEALTH MINISTER
(Signed)

Nguyễn Thị Xuyên

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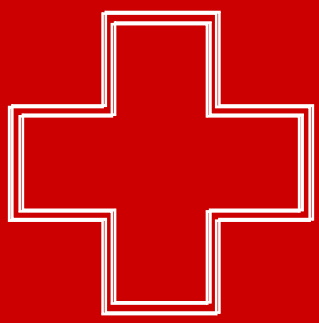

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