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Palliative Care of Elderly in Covid 19 Outbreak

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ABSTRACT

The spread of Covid 19 virus all over the globe in 2019 from Wuhan, China has posed possible threats to all the age groups of the human race. In the month of January dated 30 of the year 2020 the disease was declared as a public health emergency of International Concern and further them declared Corona virus illness as a pandemic on 11 March 2020. There had been numerous times when the virus has evolved into a new strain and many variants of the virus have emerged since the year 2021, and became dominant and spread too many countries,

With the Delta, Alpha and Beta variants are the most virulent and Omicron being the latest strain of the virus. The virus posed threats in all possible forms from economic damages to the country to attacking the lives of people. The virus has all the potential of damaging organs severely. All the classes, strata's and age groups were affected, out of which the maximum to bear the brunt of the virus were the elderly and frail patients. They contracted infections easily and could not overcome the damage virus caused to the various organs. In this review, we will be discussing then the palliative care for elderly when there are times patients cannot be admitted in the hospital or are terminally ill and the condition doesn't seem to improve in spite of all the measure taken, we resort to improve their life and decreasing their pain and discomfort. Through this article we would be discussing about all the measure that can be taken to do the same.

Key words: Covid-19, Pallative care, Treatment, Fever, Respiratory distress, Anxiety, Cough, Nausea, Delirium, Xerostomia

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INTRODUCTION

The coronavirus illness which was declared as a pandemic in 2021 caused a hundred of fatalities all over the world causing a large number of deaths in developed nations such as Europe and USA, India has been equally affected with sudden surge of cases and amidst the lockdown the medical infrastructure was put on test when the maximum geriatric patients succumbed to the virus due to various reasons. Comparing the clinical symptoms and their severity, most patients with COVID-19 illness either do not show any symptoms or remain latent or have less severe symptoms, 5% need to be hospitalized and lesser percentage of 1%–2% need special support in the form of intensive care unit (ICU) and mechanical ventilator support [1]. Death rate is relatively high in number in older adults and patients with chronic medical illness and malignancies. Elderly patients require special care and timely treatment. Some patients critically ill require pain management and supportive therapies which would provide a peaceful environment for the patient and the family.

There is an Association for Geriatric Palliative Medicine which had introduced the concept of using the method of incorporating palliative care approaches and various methods into the care of the elderly and extremely elderly sickly patients both in hospitals and att home during the treatment of the covid symptomatology. The current pandemic, as well as the publishing of the SAMS Guidelines "COVID-19 pandemic: triage for intensive-care treatment under resource constraint," motivated the FGPG to develop these practise guidelines [2]. Multiple comorbidities affect elderly adults, including diabetes, COPD, and other life-threatening lung and cardiovascular disorders. It can wreak havoc on an already weakened immune system, making them more susceptible to infection and, as a result, mortality.

When resources are scarce, rationing care is necessary

Over all, the healthcare infrastructure and healthcare professionals will not be able to offer adequate amount of support for all persons who encounter respiratory distress and failure due to the restricted and limited

number of ventilators and ICU services available. Emergency physicians, hospitalists, and intensivists will soon have to make the difficult decision of whether or not to treat a patient and also to prioritize the use of advance care and instruments in the patients, which can also be done by triage. But at the end of the day, the possibility of a patient to respond to a particular method of treatment also depends on how well his body can tolerate it and old age people have shown poor results with the usage of advance care such as ventilators and intubations, which have further led to the opportunistic infections in them and they succumbed to the latter [3].

The data in the past has proven that death numbers are directly proportional to the respective age and the number of organs affected in the person, also there is currently a scarcity of data on various death scores and indices that might help professionals make these choices. This will create a lot of confusion when it comes to making such judgments, specifically in a healthcare system that has previously prioritized decisions made by patient and his willfulness, curative treatment purpose, and technical advancements to extend life. The problem created by COVID-19 will force a paradigm shift in how healthcare providers prioritize treatment, necessitating the development of regionally applicable recommendations to assist them in advising the avoidance of ICU care when necessary [4]. Many European societies have published treatment limitation rules, linking them to wartime triage and catastrophic medicine principles. These suggestions are based on the utilitarian ethical ideal of maximizing benefit to the greatest number of people.

In USA there was a proposal made for a framework targeting multiple principles to cater care in Covid 19 which consider numerous elements including the probability of the survival of the patient, to study about it and applying various method to improve quality of life and increasing chances of survival, also let's not forget the need of skilled doctors sho play a very important role in healthcare infrastructure.Doctors should too build a strong protocol that leads to a smooth patient inflow and outflow. To minimize the co infections special measures should be taken [5].

Withholding non-beneficial treatment

The patients who were suffering from COVID-19 and who required intubation and mechanical ventilation had mortality rates of up to 86 percent, according to reports from Wuhan and Washington State.

Several old age patients and patients with severe chronic conditions opted out of intubation and mechanical ventilation due to the high death rates coming into the view. Most doctors aren't taught how to refuse

non-beneficial therapy or conduct end-of-life care discussions. The ethical concept of non-maleficence can be applied in cases where these invasive therapies are in fact likely to cause more harm and suffering than gain. In recent time, there was a proposal regarding the permission of the patients which should always be taken in such cases where health care professionals have to decide whether they have to take the patient for invasive procedure or not or if patient wants to opt out of it and live a quality life rather than living long [6].

Discussion regarding the care should be done ideally before the patient falls into more serious course of disease in order to relieve the burden of health care on the health infrastructure and also doctors should discuss the same course of treatment and ways to relief pain and in case if the patient doesn't want to be resuscitated, it should be discussed with the patient regarding do no resuscitate protocol, also it should be primarily aimed at elderly and chronically sick patients.

Symptom control and palliative interventions

Through the experience, all over the world a requirement of high skilled doctors raised tremendously aiming at providing training to the physicians on how to effectively control common presenting symptoms of covid such as dyspnea, cough, cold, body ache and mental confusion in all those patients who cannot be admitted into ICU care because either they are too ill for which adopting such ways will improve the remaining life and preserve their comfort. There may be times when there can be lack of comfort and compassion that can further cause distress and anxiety and also a feeling of burden in the patients and caregivers, as well as the healthcare team, leading to burnouts where the doctors feel like there thinking is blocked and they can't take rational decisions and feeling of fatigue persists. Such cases should be dealt with how we manage symptoms in patients immediately without burning out [7]. In addition to how doctors feel the burnout and not being able to decide, insufficient symptom control may lead to measures and practices that can raise the risk of disease transmission to healthcare personnel, such as non-invasive mechanical ventilation for dyspnoea and physical restraint placement for agitated delirium. It is very important to use a combined approach while managing patients who are critically ill by making sure we use expertise in extubating the patient also while the procedure goes on we make sure not to transmit infection through the aerosols released while doing extubation. Skilled and knowledgeable professionals can very well control the symptoms with a combined approach of palliative medicines and easy procedures which obviously formed a back bone of hospital care in the pandemic [8].

Advance care in elderly

More severe symptomatology and course of COVID-19 illness is to be expected to be experienced in elderly patients with multiple comorbidities. Even after prompt hospitalization and good care a very few mechanically ventilated patients survive and get out of the hospital. The questions remain as to how to manage elderly patient already apprehensive and anxious in the hospital environment? The elderly co morbid patients need lot of care and support and thus advance care planning is a planning which deals with the patient before at the time of ongoing infection and after the patient are diagnosed [9].

A comfortable, open, full of compassion and empathetic communication with the patient and also if the patient is willing can be done to his relatives as well forms a very important part of palliative care. In Fact it forms the backbone of palliation as a lot of patients succumb to the fear and loss of touch with their loved ones. We can explain the patient in easy to understand language, repeated and stepwise manner which helps and aids the patient to develop expectations which are realistic in nature and they are able to express his own wishes openly and to make rational choices and decisions" [10]. Try explaining the relatives and also the patient the serious nature of infection and relatives should be sensitized with the prognosis at eight times. Always explain the pros and cons and also that in spite of the best intensive care there might be threats and complications posed by the disease. The final and individuals decisions should always be discussed by the patient's acquaintance and should be properly documented and also these documentations should be kept safe and should be within the reach of the emergency physician all the time. In case he needs it, but should be promptly available. If a patient decides against the will to be treated in the hospital or any other hospital treatment, there should be arrangements ensuring that palliative care is given to the patient in a homely environment or specifically at home itself.

Palliative care measures

Given below is a table with basic pharmacological management. The medications, together with the equipment's required for their administration, must be available at the site wherever care is to be provided whether it is at hospital or palliation at home. Also with the oral form, as per requirement an alternate form should also be available so that according to the need they can be used [11]. In the following Table 1 there are some treatment recommendations for the most common symptoms experienced by the patients.

Management of psychological and social problems in critically ill patients with COVID-19 and their families

Education regarding the mental health in which honest information is given in simple, easy and precise messages, avoid giving any kind of false assurances wherein patient starts having a false hope and calm demeanor is maintained while the information is shared with the groups of people involved. Families are an important aspect of psychosocial care [12]. Coping with the illness requires support in the form of providing reassurance to the patient, easing his ventilation and affirmation of emotions, venting out specific emotions, if the patient gets angry and anxious he should be allowed to hold those emotions. Also one should promote realistic hope and goal setting. Some psychotherapeutic techniques are used such as relaxation and meditation techniques, cognitive restructuring, yoga, mindfulness, problem-solving therapy and social skills training have proven really helpful in these critical situations. Doctors should also treat emotional distress by re-establishing connection between the family members are acquaintance, end-of-life therapy such as living in dignity, maintenance of care and therapy in which the patient has been put, meaning-oriented psychotherapy, acceptance and commitment therapies should also be provided which improve end-of-life wellbeing and quality of life [13].

Patients can be started on pharmacological therapy , if in case the patient is not mentally stable and is too anxious regarding his/her disease. These pharmacological managements are implicated in the presence of some psychiatric disturbance along with some kind of therapy to support it. Drug of choice for anxiety and depression is selective serotonin reuptake inhibitors such as sertraline 100–200 mg/day and citalopram 10-20mg or citalopram can also be given. Sometimes patients may experience sudden panic attacks, not able to sleep,

Table 1: Treatment recommendations.

Symptom	Measures
Fever	Antipyretics like Paracetamol can be given in doses of 500 mg tds Metamizole can also be given in similar range of dose (500-1000mg tds)
Respiratory distress	Give supplemental oxygen, if available
	Opioid such as Morphine can be given. Morphine 2%
	Morphine hydrochloride: 2.5–5 mg subcutaneously half hourly With existing opioid treatment, increase doses accordingly
Acute respiratory distress	Add midazolam with morphine
	Midazolam can be given as nasal spray 0.5 mg
	Midazolam 1–2 mg subcutaneous almost 4 times hourly can be given
Anxiety	To alleviate mood and reduce anxiety lorazepam and other benzodiazepines can be given
	Lorazepam 1 mg can be given QID
	Midazolam can also be given same as mentioned above
Cough	To reduce cough
	Pheniramine maleate can be given which is an antihistaminic
	Codeine can be given
Pain	Morphine in cases of extreme unbearable pain
Nausea	Metoclopramide 10 mg tab stat or can be given twice a day
	Domperidone 10 mg orodispersible tab four times a day
Delirium	Haloperidol can be given
	Midazolam (as for acute respiratory distress)
Xerostomia	Regular oral hygiene

and anxiety due to diagnosis and impending doom and apprehension, also uncertain disease course which can create fear and stigma in the patients. Patient might start thinking he might not be able you recover from the disease and slowly the thread of life is getting loose for him which can create a lead point and precipitating factor in patients mental illness. In such patients' shorter-acting benzodiazepines like lorazepam, clobazam and diazepam can be prescribed. But caution should be taken to reduce the dose of the medication and stop the same once the patient's symptoms subsides as benzodiazepines have been known to cause addiction and dependence potential. Antipsychotic treatment for the patients experiencing psychotic episodes, agitation and confusion can be done by giving antipsychotics such as haloperidol and olanzapine in the doses of 2.5-5mg/day and 5-10 mg/day [14-16].

CONCLUSION

All the studies done across the globe have successfully showed how palliative care interventions and planning of care which has helped in the decreasing trend of hospital stay in the elderly patients of the disease. There are particular studies showing how palliative care interventions taken at correct time and advance care planning have often demonstrated a trend towards reduced ICU length of stay. The palliation in the hospital and at home nursing setting has shown to be really supportive in the end of life management, helps in decreasing pain, eases life, helps in communication with relatives and addressing goals of care. The palliative care has also facilitated dignified death where patient chooses to live his last moments in a comfortable environment. While the disease don't have any specific drug,but with the introduction of vaccine the disease prevalence and severity has reduced to a great extent. In elderly patients, due to various co morbid condition and old age being an immunocompromised state in itself causes very severe illness in them. Thus in elderly patients, palliation plays a key role when the patient is on the verge to succumb. Each and every patient who is in the last stage of life, expects compassion and supportive therapies either in form of medications of psychotherapy. In the above review article we have discussed various method of palliation and there importance in elderly patients. The palliation also serve the need to provide some kind of emotional support to family members and friends of the patients particularly facing sever course of disease during this infectious pandemic, with family members largely unable to visit their critically ill loved ones due to high transmission of virus. The whole of the palliation process and care has shown to reduce anxiety in the admitted patients. Although palliative care has to be merged with other spectrums of medical care, the full proof use of palliation is still not established though in a pandemic it was a very important aspect to manage elderly because we exactly don't have any particular treatment for the disease.

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