

Review Article

Understanding the Role of Dentist in Specialized Palliative Care

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Abstract

Palliative care is an approach that improves the quality of life of patients and their families through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Dentist may come across the solid tumours of head and neck region, oral manifestations of haematological malignancies, temporomandibular disorders, dry mouth and many other oral diseases. So dentist is a very important part of palliative care team. In India organisations like NNPC and Pallium India are making enormous contribution in the field of Palliative care. Kerala and Calicut model are the living examples for the provision of Palliative care to masses. The dentist's role in palliative care is to improve the quality of life of the patient.

INTRODUCTION

Palliative care is specialised medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain and stress of a serious illness — whatever the prognosis [1]. Palliative care is provided by a team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

The contemporary concept of palliative care has its origins in the modern hospice movement. Beginning with Dame Cicely Saunders and the opening of St. Christopher's Hospice in 1967, the underlying philosophy of palliation included holistic care (emphasising emotional, social and spiritual needs) taken hand-in-hand with a progressive approach to managing end-of-life symptoms medically. The movement's success is reflected in how universally accepted these goals now are, if not actually universally available yet [2].

A World Health Organisation statement [3] describes palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." More generally, however, the term "palliative care" may refer to any care that alleviates symptoms, whether or not there is hope of a cure by other means; thus, palliative treatments may be used to alleviate the side effects of curative treatments, such as relieving the nausea associated with chemotherapy.

The term "palliative care" is increasingly used with regard to diseases other than cancer such as chronic, progressive

pulmonary disorders, renal disease, chronic heart failure, HIV/AIDS and progressive neurological conditions.

Control of pain in palliative care

Pain occurs in up to 70% of patients with advanced cancer and about 65% of patients dying of non-malignant disease [4]. Much can now be done medically to make their last few weeks or months relatively pain-free. Patients frequently express the desire to have open and honest dialogue with medical carers about pain. The patient should be the prime assessor of their pain and be encouraged to take an active role in their pain management. A doctor must be able to get alongside the patient and their family and to spend time presenting options, answering questions and quelling fears. Pain is a complex subjective phenomenon and is affected by the emotional context in which it is endured [5].

Prescribing in palliative care

Wherever end of life care is undertaken, good communication and close multidisciplinary teamwork are essential. In primary care, the Gold Standards Framework [6] aims to improve the quality of palliative care by focusing on the organisation of care of dying patients. Symptom control forms one of seven key tasks of the framework (the others being: communication, co-ordination, continuity, continued learning, carer support and care of the dying). Also important is the Liverpool Care Pathway for the Dying Patient which provides a template of best practice and is now the standard for record-keeping in end of life care. Although developed for inpatient use, it can be adapted for use in the community [7]. It encompasses a management checklist including discontinuation of inappropriate treatment, provision of anticipatory medication and review of common symptoms on a daily basis.

In addition, the rapidly growing field of Palliative care

dentistry is defined as the study and management of patients with active, progressive, far-advanced disease in whom the oral cavity has been compromised either by the disease directly or by its treatment; the focus of care is quality of life [8].

Palliative dental care

Dentist may come across the solid tumours of head and neck region, oral manifestations of haematological malignancies, temperomandibular disorders, dry mouth and many other oral diseases [9]. So dentist is a very important part of palliative care team.

In every situation palliative care is beneficial as it improves the quality of life in those patients where curative treatment no longer works. While palliative care may seem to offer a broad range of services, the goals of palliative treatment are concrete. Goals of palliative care are summarised in figure 1 (Table 1).

Common oral problems in palliative care include dry mouth, painful mouth, halitosis, alteration of taste, excessive salivation, Lips Angular Cheilitis, Candida Infection Taste & Swallowing (Thrush/yeast) Disorders, Denture Stomatitis and Chronic Dehydration. They may result from poor oral intake, drug treatments, local irradiation, oral tumours, or chemotherapy. Oral symptoms may significantly affect the person's quality of life, causing eating, drinking, and communication problems, and oral discomfort and pain [12] (Table 2).

The basic principle of oral care in palliative care is focused primarily on the principle that good oral hygiene is the fundamental for oral integrity. Early clinical diagnosis of the oral lesions or conditions in the palliative patients should be done and appropriate actions must be instituted to minimize pain and suffering by giving the symptomatic relief. Mouth care is considered one of the most basic of nursing activities, and palliative care patients are especially vulnerable to oral problems [16]. The management of oral problems or lesions in palliative

patients should be carried out as a team work and definite treatment protocol should be followed by both non-dentist palliative care physician and by dental expert and it is strongly marked that palliative care is a multidisciplinary approach and role of dentist is essential to maintain optimal oral health.

Current indian scenario regarding palliative care

The state of Kerala has managed to develop an integrated health service delivery model with community participation in palliative care [17]. Institute of Palliative Medicine has been playing a major role in shaping up this model. The evolving palliative care system in Kerala tries to address the problems of the incurably ill, bedridden and dying patients irrespective of the diagnosis, age or social class. The program in Kerala is also expanding to areas like community psychiatry and social rehabilitation of the chronically ill. Palliative care has been declared by Government of Kerala as part of primary health care. Combined efforts by Civil Society Organisations, Local Self Government and Government of Kerala have resulted in the best coverage anywhere in Low and Middle Countries for palliative care in Kerala. The 'Quality of Death' study by Economist Intelligence Unit (2010) states that "Amid the lamentably poor access to palliative care across India, the southern state of Kerala stands out as a beacon of hope. While India ranks at the bottom of the Index in overall score, and performs badly on many indicators, Kerala, if measured on the same points, would buck the trend. With only 3% of India's population, the tiny state provides two-thirds of India's palliative care services. In April 2008, Kerala became the first state in India to announce a palliative care policy. The Calicut model has also become a WHO demonstration project as an example of high quality, flexible, and low cost palliative care delivery in the developing world and illustrating sound principles of cooperation between government and NGOs [18].

Community based palliative care

Since most of the patients prefer to be at home in the last



Figure 1 Goals of Palliative care.

Table 1: Palliative care by a Dentist [10,11].

A. Assessing a person with oral symptoms in palliative care	<ol style="list-style-type: none"> 1. Ask about dry mouth, oral pain, halitosis, alteration in taste, excessive salivation, bad breath, difficulty chewing, difficulty speaking, dysphagia, and bleeding. 2. Examine the oral cavity for signs of dehydration, level of oral hygiene, ulceration and vesicles, erythema or white patches, local tumour, bleeding, and infection.
B. Diagnosing the cause on the basis of clinical features alone and with some investigations done very rarely.	<ol style="list-style-type: none"> 1. Full blood count if neutropenia is suspected. 2. Platelet counts if spontaneous bleeding accompanies chemotherapy-induced mucositis. 3. Iron, folate, and vitamin B12 levels if there is recurrent Aphthous ulceration. 4. A swab to check for candida infection if clinical features are suggestive. If there is persistent or recurrent oral candidiasis species typing and sensitivity testing may be helpful.
C. Management strategies depending on the underlying cause of oral problems.	<ol style="list-style-type: none"> 1. Simple saliva stimulatory measures to treat dry mouth, such as cold unsweetened drinks, ice cubes, smearing petroleum jelly on the lips, sugar-free chewing gum or sweets. 2. Topical saliva stimulants or substitutes for refractory dry mouth. 3. Topical non-opioid analgesia for mild to moderate oral pain, and combined topical and systemic analgesia for severe oral pain. 4. Topical corticosteroids and doxycycline mouthwash for aphthous ulcers; topical or oral aciclovir for oral herpes simplex infection.
D. Referral should be considered or a specialist contacted for advice for the following conditions.	<ol style="list-style-type: none"> 1. Concern about oral intake and nutrition. 2. Refractory oral pain or excessive salivation. 3. Severe mucositis. 4. Suspected neutropenic ulcers. 5. Severe, persistent, or bleeding oral ulceration. 6. Severe or persistent candida infection. 7. Severe oral herpes simplex infection (intravenous aciclovir may be needed). 8. Prolonged taste disturbance (dietitian may help). 9. Communication problems (speech and language therapist may help).
E. When managing oral care in a person at the end of life, mouth care should be provided as often as necessary to maintain a clean mouth.	<ol style="list-style-type: none"> 1. The mouth can be moistened every 30 minutes to an hour with water from a water spray, dropper, ice chips, or sponge stick. 2. Petroleum jelly on the lips may help to prevent lip cracking. 3. A room humidifier or air conditioning can be used if needed. 4. Pain should be managed symptomatically, using analgesics via a suitable route.

Table 2: Management of some common oral problems by Palliative care [13,14,15].

Dry Mouth	<p>A. Treating the patient who is alert and capable of oral intake:</p> <ul style="list-style-type: none"> • Suggest the patient suck sour fruit candies, ice chips, popsicles or raw pineapple. Try to increase oral fluids. Use mouthwashes and oral lubricants regularly (see below). <p>B. Treating the patient who is not capable of oral intake:</p> <ul style="list-style-type: none"> • Cleanse the mouth every two hours with benzydamine HCL half strength, or with Orarinse, Biotene or a similar mouthwash product. Follow with lubricant, such as Artificial Saliva, K-Y jelly, Moi-Stir spray or pre-moistened swab sticks. <p>C. Treating both groups of patients with very dry lips, oral and nasal mucosa:</p> <ul style="list-style-type: none"> • Administer nebulized saline 3 cc by ventimask over mouth and nose every four to six hours. • Use a humidifier in the room; if oxygen is in use, add humidification. • Apply petroleum jelly to the lips every two hours.
Oral crusting and debris in the mouth	<ul style="list-style-type: none"> • Use half-strength hydrogen peroxide rinses every four to six hours until clean and then institute mouth-care orders as above.
Oral candidiasis	<ul style="list-style-type: none"> • Prescribe regular cleansing with a mouthwash, followed by Nystatin oral solution 500,000 units to swish and swallow four times daily for 10 to 14 days. • If the condition is severe or does not resolve, systemic oral or intravenous antifungal agents may be required.
Ulceration and stomatitis	<ul style="list-style-type: none"> • Use normal saline or baking soda (one tsp of either in 8 oz of water) rinses to cleanse every one to two hours; • Mouthwash (Diphenhydramine 12.5 mg/5 ml elixir, • Nystatin 100,000 units/1ml suspension, Distilled water to rinse and spit every two to three hours; • Apply petroleum jelly to the lips every two hours; • Mouthwash with Viscous xylocaine 2% and magnesium hydroxide/aluminum hydroxide as required for pain relief; if the condition is severe or infected or if the patient is ill, oral or intravenous antibiotics may be required. • For pain relief: oral codeine syrup, 15 mg to 30 mg every four hours, may be used as needed. Oral morphine syrup may also be used (oral morphine 5 mg equals 60 mg of oral codeine). • If the subcutaneous route is required, the dose is one half of the oral dose for both opioids.

phase of their life, it will be ideal if palliative care services are available to them in the community. Community Based Palliative Care is the term commonly used to refer to palliative care services organised by the local community, with home based care as its corner stone. Community based palliative care services also has good participation from the members of the local community. Palliative care institutions should be available to support these community based home care programs. The term 'Hospice' was originally used to denote a standalone inpatient palliative care service. In many cultures, the term later became synonymous with palliative care. A lot of people use the terms hospice care, palliative care and end of life care interchangeably.

CONCLUSION

Palliative care patients require special dental attention. In India organisations like NNPC and Pallium India are making enormous contribution in the field of Palliative care. Masses are also unaware about the role of dentist in palliative care. The palliative care movement is one example of how health services can go well beyond the biomedical model of health and be seen as an affirmative act of living with dignity even whilst accepting that death is an inevitable part of life. This extends from operative and preventive care to the concept of total patient care covering both the physical and emotional aspects of well-being. The dentist's role in palliative care is to improve the quality of life of the patient.

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