The principles of symptom control

The core medical skills of history taking, examination and investigation form the heart of every patient encounter. Undergraduate and postgraduate curricula have this process as the bedrock of medical training. The core competencies outlined in the generic postgraduate training curriculum (Federation of the Royal Colleges of Physicians, 2006a) have good clinical care with good history taking and examination as the first area of expertise. Thus doctors are taught and trained, quite rightly, to diagnose the underlying pathology.

However, there is less focus on the importance of assessing the symptoms themselves although this is now written into the clinical scenarios of the general internal medicine specialty curriculum (Federation of the Royal Colleges of Physicians, 2006b), is a key feature of specialist palliative medicine training (Joint Royal Colleges of Physicians Training Board, 2007) and is part of the general surgery training syllabus for patients who are terminally ill (Intercollegiate Surgical Curriculum Programme, 2007). Symptom assessment and control is a generic skill, required by doctors at all stages of their training, in all specialities and may be required by patients at all stages of their illness.

Failure to give systematic attention to this area may leave a patient in distress either during a prolonged diagnostic process, during prolonged response of the underlying disease to treatment, or as a result of unresponsive underlying disease. Metastatic bone disease may respond well to palliative radiotherapy, but may take several weeks before the pain improves unless other symptom measures are taken. A patient with advanced heart failure may have significant breathlessness despite being at dry weight and on optimal medical therapy.

Sigurdardottir and Haugen (2008) highlighted the symptom prevalence in patients on general medical wards and call for doctors to be skilled in symptom control. Symptom control is now entering the curriculum of most UK medical schools, although still usually in the context of patients with malignant disease. Symptom prevalence has been documented in several non-cancer patient populations – heart failure, chronic obstructive pulmonary disease, and renal disease (Janssen et al, 2008) – but very little research with symptom control as a prime end point exists other than in pain.

Patients are clear that symptoms impact greatly on their lives and symptom control is a priority. However, it can be easy to forget symptom control in the hunt for the illness itself. Good symptom control is built on four key steps: careful assessment using the same principles of history, examination and investigation, reversal of reversible factors if appropriate, palliation of irreversible factors and regular review.

Assessment

The aetiology of the symptom often has an important effect on its management. For example, the pain caused by nerve infiltration by a malignant tumour may require different management to the pain caused by a renal stone. It would be inappropriate to treat pain caused by constipation with an opioid analgesic, and potentially harmful to treat the vomiting from complete bowel obstruction with a prokinetic agent such as metoclopramide.

An understanding of relevant pathophysiological mechanisms involved in pain has helped improve the choice of the available analgesic and adjuvant analgesics (Woolf, 2004). A similar approach can be used in other symptoms.

Many symptoms are affected by non-physical factors. Anxiety, depression, financial worries, family or work distress or spiritual concerns all contribute and respond poorly to medication alone. It is important to distinguish these aspects and time spent at the outset often prevents incorrect treatment which leaves the symptom unresolved and adds further unwanted effects. Access to and close working with the multiprofessional team is mandatory for optimal symptom management.

Reverse the reversible

Look for and treat reversible factors if appropriate. A cancer patient may be confused and vomiting as a result of hypercalcaemia which may resolve with bisphosphonate therapy and rehydration. A patient with chronic heart failure may be dizzy on standing and falling, with lethargy and weakness caused by overdiuresis which will respond to optimization of diuretics. The nausea caused by non-steroidal anti-inflammatory drug-induced renal failure will resolve if the kidneys recover on stopping the offending medication. However, it is important to treat the symptom as well – the renal failure may take several days to settle during which time the patient may need an anti-emetic, such as haloperidol.

It is important to plan management considering the patient's overall condition. If the patient is clearly dying, then treatment may be futile, for example, a bronchopneumonia in a patient with end-stage motor neurone disease with ventilatory failure. It is important to be aware of treatment limitations and to offer wisely. Treatment decisions should be reached taking the patient's wishes into account where possible and in accordance with the Mental Capacity Act where it is not.

It is key to ensure the patient is on optimal tolerated treatment for the underlying condition, as many with long-term conditions such as chronic heart failure, chronic obstructive pulmonary disease or diabetes are not.

Palliate the irreversible

The symptom assessment should guide the choice of medication or other management, and the treatment should be titrated against the severity of the symptom. Decision making should involve the patient and carers, taking into account the stage of the illness and the likely benefit of any intervention.

Regular review

This, as well as the initial assessment stage, is commonly omitted. The initial and review assessments should include some measure of symptom severity so a quantitative judgment can be made regarding the effectiveness of the treat-

ment. A 0–10 numerical rating scale or a 100 mm visual analogue score is simple to use in the clinical setting. Review should be timely and planned. It should be clear which clinician has ongoing responsibility, particularly on hospital discharge and failure to do this can lead to serious consequences.

Conclusions

Symptom control is a patient priority. It should be given specific consideration alongside the differential diagnosis and management of the underlying disease. Four key steps are required: assessment (including a measure of severity), reversal of reversible factors, palliation of irreversible factors and regular review. Understanding the relevant pathophysiological mechanisms helps tailor treatment choices to the individual. The symposium in this issue contains articles describing symptom control approaches for key symptoms and provides useful guides to management. **BJHM**

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Federation of the Royal Colleges of Physicians (2006a) *Generic Curriculum for the Medical Specialties.* www.pmetb.org.uk/fileadmin/user/QA/Curricula/Approved_curricula/GENERAL_INTERNAL_MEDICINE__Acute_/generic_curriculum_-_may_07.pdf (accessed 3 March 2009)

Federation of the Royal Colleges of Physicians (2006b) *The Physician of Tomorrow Curriculum for General Internal Medicine (Acute Medicine).* www.pmetb.org.uk/fileadmin/user/QA/Curricula/Approved_curricula/GENERAL_INTERNAL_MEDICINE__Acute_/GIM_3_Jul_07_v.Curr_0014.pdf (accessed 3 March 2009)

Intercollegiate Surgical Curriculum Programme (2007) General Surgery Syllabus. www.pmetb.org.uk/fileadmin/user/QA/Curricula/Approved_curricula/Surgery/General_Surgery_Syllabus_01.pdf (accessed 3 March 2009)

Janssen DJA, Spruit MA, Wouters EFM, Schols JMGA (2008) Daily symptom burden in end-stage chronic organ failure: a systematic review. *Palliat Med* **22**(8): 938–48

Joint Royal Colleges of Physicians Training Board (2007) *Specialty Training Curriculum for Palliative Medicine.* Royal College of Physicians, London (www.pmetb.org.uk/fileadmin/user/QA/Curricula/Approved_curricula/PALLIATIVE_MEDICINE/Palliative_medicine_3_Jul_07_v.Curr_0025.pdf accessed 3 March 2009)

Sigurdardottir KS, Haugen DF (2008) Prevalence of distressing symptoms in hospitalised patients on medical wards: A cross-sectional study. *BMC Palliative Care* **7:** 16

Woolf CJ (2004) Pain: moving from symptom control toward mechanism-specific pharmacologic management. *Ann Intern Med* **140:** 441–51

KEY POINTS

- Patients perceive control of symptoms as very important.
- Symptom control should be systematically addressed with assessment, reversal of remedial factors, palliation of non-remedial factors and regular review.
- Symptom control is a generic skill that all doctors should be able to demonstrate.
- Specialist palliative care teams can help with resistant or persistent symptoms.