

## HOSPITAL PALLIATIVE CARE FOR PATIENTS WITH HEPATOCELLULAR CARCINOMA

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**Abstract:** *Hepatocellular carcinoma (HCC) is one of the leading causes of cancer death. We conducted a retrospective study in a hospital-based palliative care for 62 patients with HCC (69.3% male, all older than 50yr. 76.7% married) who were followed in General Hospital Uzice, between of June 2000. to December 2015. The most common symptoms of HCC patients were pain, fatigue, weakness, anorexia, vomiting, peripheral edema, cachexia, and ascites. Hypoalbuminemia, anemia, hyponatremia and jaundice were common laboratory abnormalities. Upper gastrointestinal bleeding or varices bleeding developed in 50 (80.6%) patients . Fifty-eight (93.5%) patients died at the hospital. Median hospitalization was 42 days. In conclusion, symptoms and signs of terminal phase of HCC patients are unique and should be managed appropriately.*

**Keywords:** *hepatocellular carcinoma, hospital, palliative care*

### 1. INTRODUCTION

Palliative care is specialized medical care for people living with a serious illness. Palliative care is provided by a specially-trained 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 it can be provided along with curative treatment. The goal of palliative care is improve quality of life for both the person and their family [1]. It focuses on providing relief from the symptoms, pain, physical stress, and mental stress at any stage of illness.

Hepatocellular carcinoma (HCC) is a global health problem, the fifth most common cancer in the world. It is the fifth most common of all malignancies and causes approximately one million deaths annually worldwide [2]. HCC occurs in a histologically abnormal liver due to underlying chronic liver disease resulting as a sequele of the chronic viral infections, hepatitis B and C. HCC is often diagnosed at advanced stages and prognosis is generally poor when the tumor is unresectable [3, 4]. This extremely guarded prognosis is frequently coupled with severe symptom occurrence including pain, fatigue, anorexia, and ascites [5]. This in turn impacts patients quality of life (QOL) and functional status.

### 2. PATIENTS AND METHODS

We analyzed findings of a total 62 patients with HHC who were treated and followed up in General Hospital in Uzice, from January 2000. to December 2015. We reviewed the following aspects: demographic, clinical and biochemical parameters and medical treatment. All patients have been done alpha-1 fetoprotein (AFP) [6], abdominal ultrasound, computed tomography and/or magnetic resonance imaging and and histological analysis. Diagnosis was based on EASL consensus diagnostic criteria for HCC [7].

Patients with end stage or terminal HCC are those presenting with tumors leading to a very poor Performance Status (ECOG 3–4) or Child–Pugh C patients with tumors beyond the transplantation threshold [8] which correspond to patient with BCLC class D.

### 3. RESULTS

Demographic characteristics are shown in Table 1.

**Table 1.** Demographic characteristics

Demographic characteristics	Patients No. (%)	P
Male/female	43/19 (69.3/30.6)	0.070
Age <50>	0/62 (0/100)	0.00
Married/not married	48/14 (77.4/22.6)	0.002

P - statistical significance between patients according to the parameters

All patients were older than 50 years. Most of them were men. A significantly larger number was married.

The symptoms and signs are shown in Table 2.

**Table 2.** The symptoms and signs

Symptoms and signs	Patients No. (%)
Weakness	57 (91.9)
Fatigue	60 (96.8)
Abdominal pain	31 (50.0)
Anorexia	59 (95.2)
Nausea and vomiting	46 (74.2)
Peripheral edema	29 (46.8)
Cachexia	49 (79.0)
Ascites	60 (96.8)
Constipation	60 (96.8)
Sleep disturbance	51 (82.3)

The vast majority of patients had fatigue, ascites, constipation, anorexia and weakness. Most of patients had cachexia, nausea and vomiting, half of patients had pain.

The laboratory parameters are shown in Table 3.

**Table 3.** The laboratory parameters

Symptoms and signs	Patients No. (%)
Erythrocytes No. (%) of persons < 4.10 x10 <sup>12</sup> /L	56 (90.3)
Hemoglobin < 12g/dL	55 (88.7)
Thrombocytes < 150 x10 <sup>9</sup> /L	62 (100)
Bilirubin (direct) > 0.4 mg/dL	51 (82.3)
Proteins < 6.0 g/dL	62 (100)
Albumins < 3.4 g/dL	60 (96.8)
Sodium < 135 (mEq/L)	60 (96.8)

All patients had thrombocytopenia, hypoproteinemia, most of them had anemia, hyponatremia and jaundice.

Hospitalization lasted average 42 +/- 10.2 days. Upper gastrointestinal bleeding or varices bleeding developed in 50 (80.6%) patients. The most common metastatic sites were bone (57.3%) and lung (42.7%). Fifty-eight (93.5%) patients died at the hospital.

#### 4. DISCUSSION

Palliative care is an approach that improves the quality of life of patients and their families facing the problem 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 [9]. HCC patients in the terminal stage of disease may present with a variety of symptoms related to decompensated cirrhosis including ascites, variceal bleeding, peripheral edema, and hepatic encephalopathy.

Besides these symptoms, our patients most often had fatigue, ascites, constipation, anorexia and weakness. The result is consistent with the research of Kumar and associates [4], as well as Lin and associates, too [10]. Sleep disturbance is one of the factors for feeling fatigue [11]. Pharmacological regulation of insomnia helped to reduce fatigue in our patients. Bowel movements vary in frequency between individuals. Risk factors for constipation in our patients were older age, decreased physical activity, low fiber diet, to take opioids, calcium channel blockers, diuretics, anticholinergic drugs and metabolic abnormalities (hypokalemia). Treatment of constipation included bulk-forming laxatives (cellulose), and osmotic laxatives (lactulose, magnesium hydroxide). The accumulation of ascites is a result of an imbalance in the normal state of influx and efflux of fluid from the peritoneal cavity. Diuretics remain the standard in management of ascites what we used to do with our patients.

Anorexia is besides weight loss, a leading symptom of the primary metabolic cachexia syndrome, therefore a common term for cancer wasting syndrome is anorexia-cachexia syndrome [12]. Cachexia was contributed by the hypoproteinemia/hypoalbuminemia that was present in all of our respondents. We took parenteral compensation for albumin. Megestrol acetate has gained a significant effect in the treatment of cachexia [12], but it was available to a small number of our patients. Nausea and vomiting were less present in our patients. This is due to the fact that a small number of our patients had chemotherapy/radiation-related therapy. Metoclopramide was our first choice. We did not use glucocorticoids that may provide benefit for patients with elevated intracranial pressure, and for patients with malignant bowel obstruction. The use of medical marijuana for refractory nausea in terminally ill patients is very controversial in the world [13]. Medical use of marijuana is not legal in Serbia.

Trials of parenteral nutrition [14] and supplements [15] included patients with HCC. The current data do not compellingly justify the routine use of parenteral nutrition, enteral nutrition, or oral nutritional supplements in these patients. Quality of life is certainly the most important criteria in patients with terminal cancer in general and is mainly dependent on nutritional status [16].

Abdominal pain has been reported [4, 10] as the most common symptom which originated from enlarged tumor mass and was characterized as dull visceral pain. This symptom was half of our respondents. Abdominal pain may be categorized as parietal or visceral. Abdominal pain in HCC is due primarily to visceral involvement that originates from a primary or metastatic lesion involving the abdominal or pelvic viscera [17]. We used acetaminophen and opioids, to avoid non-steroidal antiinflammatory drugs that increase the risk of variceal hemorrhage, impaired renal function, and the development of diuretic resistant ascites. Acetaminophen appears to be safe in patients with advanced chronic liver disease or cirrhosis when used at the recommended doses [18].

Anxiety and depression were present in our patients, but we did not determine their level. Patients diagnosed with HCC were found to have the third highest reported level of psychological distress or depression among patients with 14 other types of cancer [19]. Successful treatment of depression or anxiety in cancer patients often requires a combination of pharmacologic and nonpharmacologic interventions [20]. We used pharmacotherapy (benzodiazepine). Cognitive-behavioral therapy was not available to our patients. The vast majority of our patients died in the hospital, although they had their wife/husbands. This can be explained by the inability of family members to provide the necessary care to what is greatly affected by the conditions of life.

#### 5. CONCLUSION

The patient has the right to the best quality of life to his end. Hospital palliative care for patients with HCC includes nutrition, pain and symptoms management, as well as satisfying psychosocial needs. It is necessary national guidelines, recommendations and standards for palliative care.

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