Improvement of transurethral catheterization in male patients

Retention of urine in the bladder is common in palliative care, for a number of reasons. Among these, the most important are neurological deficit, a decreased level of consciousness, urinary infection, pelvic tumour, benign prostatic hypertrophy, and the use of opioids and tricyclic antidepressants. Urinary retention may be responsible for incontinence, restlessness, confusion, bladder infection and sepsis, spasm and abdominal pain.

Urinary retention is usually treated by transurethral bladder catheterization. This may be difficult in terminally ill patients because of restlessness, a lack of co-operation, and dehydration of the urethral mucosa with consequent pain during the procedure. Narrowing of the external sphincter and prostatic urethra may be difficult to pass through because of anatomical abnormalities, benign prostatic hypertrophy, oedema caused by earlier attempts at catheterization or tumour growth. In these situations there may be a need for insertion of a suprapubic catheter. In most circumstances this will require hospital attendance and an invasive, sometimes painful procedure.

We propose here a new and safe method of transurethral bladder catheterization. More than 65 terminally ill male patients have been catheterized according to this protocol over the past 5 years. All procedures were successful and no patient needed a suprapubic catheter.

The urethra is initially catheterized with a self-lubricating, thin (Ch 14), disposable, polyethylene catheter. The conic collar of the disposable catheter is cut off to allow connection to a Luer syringe containing sterile lignocaine 2% gel. The urethra is filled first in the usual way and the catheter is then pushed gently until resistance is felt, around 15–18 cm from the urethral orifice. The catheter tip is now probably close to the external sphincter. With the catheter in position, 10 ml 2% xylocaine gel is then instilled through the catheter, which is then gently withdrawn. By this manoeuvre the whole urethra distal to the prostate is filled in a retrograde way. The penis is then clamped between two fingers to prevent the gel leaking out. After 5–7 min catheterization with a normal urethral catheter will be much easier because the most vulnerable and painful part will be well anaesthetized, and because sufficient lubrication will be provided.

The idea of this method is to pass a catheter after the whole urethra is filled with lubricating anaesthetic gel thus providing enough time for the pharmacological effect of the local anaesthetic drug and optimal lubrication. Using the traditional anterograde lubricating method, probably only the first few centimetres of the urethra are properly lubricated. The resistance of the dehydrated urethra may be high and the rest of the injected gel will leak out of the urethral orifice, incorrectly suggesting that the whole urethra has been filled. When approaching the most vulnerable part of the urethra, the external sphincter, the catheter tip will then be dry. Even if not, contact between the lubrication gel congested in front of the catheter and urethral mucosa may be brief and not long enough to provide local anaesthesia.

The method proposed involves passing two catheters and is somewhat more invasive than the traditional method, but in some patients, where problems may be expected, the increased invasiveness of this method may be preferred above the likelihood of a much more invasive suprapubic catheterization. It is not known to what extent local anaesthetic contributes to the ease of the procedure. Some urologists feel that the most important contribution of local anaesthetic gel is to provide lubrication. However, it is essential to wait 5–7 min to allow the local anaesthetic to work, and this time may not always be available. In our experience taking time for the procedure is usually rewarding to both the patient and the doctor or nurse who
performs the procedure, given the significant reduction in the pain usually experienced.

Zbigniew Zylicz, Medical Director of Hospice Rozenheuvel, Rozendaal, The Netherlands and Malgorzata Krajnik, Department of Palliative Medicine, The Ludwik Rydygier Medical University, Bydgoszcz, Poland.

The decision-making process in sedation for symptom control in Japan

We were very interested to read the recent report on sedation for symptom relief. Although sedation has been actively discussed for several years, the resulting decision-making process and psychological distress have been neglected. We would like to present our current practice in Japan and a few comments on the above two topics.

It is necessary to clarify the definition of sedation because confused, insufficiently described terminology has led to difficulty in interpreting various studies. We define sedation as ‘a medical procedure used to palliate patients’ symptoms refractory to standard treatment by intentionally clouding their consciousness’, and propose a classification by primary–secondary, intermittent–continuous, and mild–deep subcategories. Primary sedation is a therapeutic intervention, the primary goal being to lower patients’ consciousness (for example, administration of benzodiazepines for agitated delirium), while secondary sedation allows somnolence produced by prescribed opioids to palliate underlying discomfort (for example, opioid escalation up to somnolence for severe dyspnoea). Intermittent sedation provides some periods when patients are alert by intermittent use of sedatives, while continuous sedation alters the patients’ consciousness until death. Mild sedation maintains the patients’ consciousness to a degree such that they can communicate with carers, while deep sedation leads patients to unconsciousness. Thus, theoretically, there are 8 (= 2³) subtypes of sedation for symptom control. In our terms, the recent definition by Chater et al. could be classified into primary–continuous–deep sedation, but may exclude secondary, intermittent, or mild subtypes. Further research on sedation should be encouraged to clarify the definition in more detail.

We have summarized below a prospective study to describe the decision-making process of 87 sedated terminally ill cancer patients (47% of all deaths between June 1996 and October 1997). On commencing sedation, physicians were requested to record the details about the explanation given to care receivers about sedation on a structured data-collecting sheet designed for this study. Physicians were encouraged to explain clearly:

1) the difficulty of recovery and severity of present suffering;
2) the absence of other methods applied for symptom relief;
3) possibility of somnolence, undesirable effects, and that their level of consciousness might not improve.

If physicians had a clinical reason for determining that an explicit explanation was impossible or undesirable, the reasons were noted. Physicians also assessed possible factors affecting patients’ judgements:

- psychiatric disease;
- ambivalence of patients’ wishes for sedation;
- lack of objectivity of physical distress for which sedation was considered;
- contributing factors to patients’ voluntary decision (i.e. lowered self-esteem, physical/emotional exhaustion of family members, and economic problems);
- initial conflicts about sedation among family members or staff.

The patients consisted of 53 males and 34 females, whose mean age was 63 ± 15 years. They stayed at our hospice for a median of 30 days (range = 2–306). Primary tumour sites were the gastrointestinal tract (n = 34), lung (n = 21), genitourinary system (n = 11), liver/pancreas/gallbladder (n = 10), breast (n = 3), and others.

The types of initial sedation according to our definition were: primary (61%) and secondary (39%); intermittent (67%) and continuous (33%); mild (51%) and deep (49%). Most frequent forms of sedation were: primary–intermittent–deep (38%), secondary–intermittent–mild (21%), and secondary–continuous–mild (16%). Main symptoms requiring sedation were: physical restlessness with or without delirium (67%), dyspnoea (40%), pain (18%), nausea (6%), and convulsion (1%). Sedated
patients died a median of 3.0 days (range = 1–50) after sedation began.

Table 1 shows the percentage of patients and their family members who received an explicit explanation concerning sedation. More than 90% of the family members were clearly informed of the risks and benefits of sedation. A considerable number of patients could not receive an explicit explanation, particularly when they were delirious. The main reason why physicians did not explain to delirious patients was due to the lack of patients' decision-making capacity. In nondelirious cases, physicians often intentionally avoided a clear explanation to protect the patients from anxiety. In a smaller number of the cases, physicians were expected to be decision makers, or did not have enough time to explain due to the sudden onset of suffering.

Table 2 shows the frequency of possible influencing factors on decision-making, for those cases where there was, and for those where there was not, an initial conflict on sedation among family members and medical staff. Delirium, ambivalence of patients' wishes, and lack of objectivity of distress were significantly associated with a difficulty in making a decision for family members. Also, lack of objectivity of distress and conflicts on sedation in family members contributed to a difficulty in making a decision for staff.

In summary, this study outlines that the decision-making process in sedation is influenced by various physical and psycho-social factors which have not been satisfactorily examined in medical literature.

Finally, we would like to comment briefly on sedation for psychological distress. In Japan, there is no legislation on end-of-life medical treatment. However, in 1993, the Yokohama District Court stated that indirect euthanasia, defined as ‘a medical practice to palliate patients' suffering in impending death under the conditions where intervention could hasten death in consequence’, can be accepted only for physical distress. According to the above definition, sedation, especially a continuous–deep subtype, could be interpreted as a form of indirect euthanasia, because there is no consensus that it does not have a life-threatening potential. Thus, continuous–deep sedation for patients without unendurable physical suffering could be subject to legal criticism, even when the patient cannot tolerate psychological or spiritual distress. In these circumstances, we believe that continuous–deep sedation is not an option for pure psychological distress, and would like to stress the importance of other forms of sedation (i.e. intermittent and mild sedation).

Table 1

<table>
<thead>
<tr>
<th>Explicit explanation to patients and family members</th>
<th>To patients (%)</th>
<th>To family members (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With delirium</td>
<td>Without delirium</td>
</tr>
<tr>
<td></td>
<td>(n = 49)</td>
<td>(n = 38)</td>
</tr>
<tr>
<td>Difficulty of recovery</td>
<td>51 (n = 25)</td>
<td>79 (n = 30)</td>
</tr>
<tr>
<td>Severity of present suffering</td>
<td>76 (n = 37)</td>
<td>89 (n = 34)</td>
</tr>
<tr>
<td>Absence of other methods applied for symptom relief</td>
<td>55 (n = 27)</td>
<td>82 (n = 31)</td>
</tr>
<tr>
<td>Possibility of somnolence</td>
<td>49 (n = 24)</td>
<td>61 (n = 23)</td>
</tr>
<tr>
<td>Possibility that they might not wake up again</td>
<td>4 (n = 2)</td>
<td>13 (n = 5)</td>
</tr>
<tr>
<td>Possibility of severe undesirable effects</td>
<td>0</td>
<td>11 (n = 4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Disagreements among family members</th>
<th>Disagreements among medical staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Presence (n = 24)</td>
<td>Absence (n = 63)</td>
</tr>
<tr>
<td>Delirium</td>
<td>75 (n = 18)</td>
<td>49 (n = 31)</td>
</tr>
<tr>
<td>Ambivalence of patients' wishes</td>
<td>42 (n = 10)**</td>
<td>13 (n = 8)</td>
</tr>
<tr>
<td>Lack of objectivity of distress</td>
<td>21 (n = 6)</td>
<td>5 (n = 3)</td>
</tr>
<tr>
<td>Contributing factors to patients’ voluntary decision</td>
<td>25 (n = 6)</td>
<td>14 (n = 9)</td>
</tr>
<tr>
<td>Disagreements among family members</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

*P < 0.05, **P < 0.01, chi-squared test (Fisher’s exact method).
Tatsuya Morita, Junichi Tsunoda, Satoshi Inoue, Satoshi Chihara, Seirei Hospice, Seirei Mikatabara Hospital, Shizuoka, Japan.

References


The use of amitriptyline in mycosis fungoides

I would like to report the use of amitriptyline in symptom control in Sézary syndrome, a variant of mycosis fungoides.

Mycosis fungoides is a type of progressive T-cell lymphoma, which presents with a scaly skin eruption progressing to skin tumours. The disease predominantly affects middle-aged men, and it can be present for many years before lymphatic involvement. The Sézary syndrome is a leukaemic variant of mycosis fungoides, which presents as an eczematous skin eruption progressing to intense pruritis with shedding of the skin. Mean life expectancy is 5 years.

Case report

A man in his 50s presented to his general practitioner in 1986 with generalized pruritis. No diagnosis was made at that time, but allergies were excluded. Eight years later he became very ill with severe pruritis, shedding of the skin, especially of the hands, feet and face and lymphadenopathy. An eventual diagnosis of Sézary syndrome was made, and photophoresis treatment was started, with excellent relief initially. However, he found increasingly that life was difficult to face, and was referred to his local palliative care service.

His principal problems were of widespread itching and the feeling that peripheral nerve endings were ‘on fire’. He was given amitriptyline 25 mg at night, with good results. The itching eased, and the feeling that his nerve endings were ‘raw and exposed’ lessened considerably. He felt much more comfortable, and his quality of life was greatly improved, perhaps in part due to the antidepressive action of amitriptyline. Unfortunately, his symptoms returned after a few months, but they responded to an increase in the dose of amitriptyline to 50 mg at night.

Amitriptyline is widely used in neuropathic pain, but the present situation does not involve direct entrapment of nerve trunks, and we are not aware of any previous reports of the use of amitriptyline in this condition.

Penny Coe, Pilgrims Palliative Advisory Nurse, Pilgrims Hospice, Canterbury, Kent, UK.

Reference