

THE IMPORTANCE OF PALLIATIVE CARE IN PATIENTS WITH SEVERE AND CHRONIC FORMS OF TUBERCULOSIS

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DOI: 10.5958/2249-7137.2022.00159.8

ABSTRACT

Palliative care is an approach aimed at improving the quality of life of patients and their families who have problems with life-threatening illness. The aim of the study was to determine the need for palliative care in patients with severe and chronic forms of tuberculosis. This study involved 43 patients with severe or moderate TB. We used the HADS scale to help determine the level of anxiety and depression in patients, the Charlson scale to determine the degree of comorbidity in patients under long-term follow-up, and the Visual Analog Scale (VAS) to assess chronic pain. In summary, treatment of patients with severe and chronic forms of tuberculosis requires palliative care, including medical and psychological interventions.

KEYWORDS: *Palliative Care, Severe And Chronic Forms Of Tuberculosis, Patients, Scale.*

INTRODUCTION

According to the World Health Organization (WHO), palliative care is an approach aimed at improving the quality of life of patients (adults and children) and their families with life-threatening illness-related problems. It alleviates and alleviates patients 'suffering through early diagnosis, proper assessment and treatment of pain, as well as resolving physical, mental or psychosocial problems [1,2]. The prevalence of multidrug-resistant tuberculosis (MDR-TB) and broad-drug resistant tuberculosis (XDR-TB) forms the basis for the WHO's declaration of palliative care in phthisiology. In December 2010, at a meeting of international experts on tuberculosis control, a declaration on palliative care for patients with tuberculosis was adopted. It states that "patients with MDR-TV / XDR-TV should receive palliative care in case of ineffective results, despite the fact that they receive twice the full course of controlled chemotherapy" [3,4,5]. This postulate was later supplemented with "or two refusals of treatment". The emergence of new drugs such as bedaquiline and delamanid, as well as the

adoption of the END TB strategy, have confused TB physicians and undermined the palliative care options previously widely discussed internationally [6,7,8,9].

An increase in the number of patients with MDR-TV / XDR-TV, insufficient adherence to treatment, limited range of anti-tuberculosis drugs, co-occurrence of tuberculosis and HIV infection - all this leads to the development of incurable forms of tuberculosis [10,11,12]. In some patients, even the tuberculosis process cannot be surgically removed. In such cases, prescribing anti-tuberculosis drugs for chemotherapy is not only ineffective, but leads to the development of total stagnation in all anti-tuberculosis drugs. In this regard, in 2012, the international community of phthisiologists adopted a declaration on the provision of palliative care. It states that "palliative care should be provided to patients with MDR-TV / XDR-TV. The main criterion for the transfer of patients to palliative care is that the course of treatment prescribed to them does not give a positive result twice, or the course of treatment is interrupted "[13].

Purpose. To determine the need for palliative care in patients with severe and chronic forms of tuberculosis.

Materials and inspection methods. In this study, in 2021, 43 patients with severe or moderate conditions were treated in the treatment departments of the Samarkand Regional TB Dispensary. Such patients did not participate in the study because their condition was severe and difficult to communicate with patients with tuberculous meningitis. A.S., which helps determine the level of anxiety and depression in patients. Zygmund and R.P. We used the HADS scale developed by Snaith, the Charlson scale to determine the degree of comorbidity in patients under long-term follow-up, and the Visual Analog Scale (VAS) to assess chronic pain.

The results of the investigation and their discussion. The mean age of the patients was 42.1 ± 3.4 . The incidence of clinical forms of tuberculosis is as follows: fibrous-hollow tuberculosis in 27 (62.7%) patients, diffuse tuberculosis in 12 (27.9%) patients (including generalized form), and caseous in 4 (9.4%) patients. zotiljam was observed. HIV infection was detected in 9 (20.9%) patients. All patients underwent chemotherapy with primary and reserve medications. Antiretroviral therapy was also given to 7 patients.

Shortness of breath, as well as signs of respiratory failure, were observed as the leading clinical symptom in 29 (67.4%) patients. Pain syndrome was reported in 15 patients, and 7 (16.3%) patients reported that the syndrome predominated in them. Dull pain was observed in 4 patients, burning pain in 2 patients, acute pain in 2 patients, puncture pain in 6 patients and pressure pain in 1 patient. 2 patients were diagnosed with persistent pain and 13 patients with recurrent pain. As pain-enhancing factors, patients reported: physical activity (4), changes in body position (3), deep breathing and coughing (9), fever (1), and taking anti-tuberculosis medications (2). The following factors were noted as pain relievers: lying on your back (5), taking painkillers (6), and taking cough suppressants (8). Two patients reported that no remedy relieved the pain.

All patients needed symptomatic medications and treatment of comorbidities. During the last hospitalization, patients received sputum transplant agents (41 (95.3%) patients), hepatoprotectants (37 (86%) patients), proton pump blockers (34 (79.1%)) in addition to TB treatment. patients), nonsteroidal anti-inflammatory drugs (24 (55.8%) patients), antiemetics (19 (44.1%)), antispasmodics (17 (39.5%)), antihistamines (16 (37.2%), bronchodilators and broad-

spectrum antibiotics (15 (34.8%)), antidiarrheal drugs (12 (27.9%)) and laxatives (11 (27.9%)).), hemostatics (10 (23.2%)), diuretics (10 (20.9%)), glucocorticoids (9 (20.9%)).

Almost all patients (41 (95.3%)) asked, “Do you need help from a psychologist?” they answered in the negative. According to the HADS scale, which helps to determine the level of anxiety and depression, significant anxiety was detected in 14 (32.5%) patients and depression in 18 (41.8%) patients. The mean on the depression scale was 15 ± 7.8 . In 28% of cases, patients were found to suffer from both anxiety and depression. Several patients reported that they did not have relatives to care for them. In addition, it was found that the attitude of medical staff to patients was high (average 4.75 points). [14]

From the above, it can be seen that patients with severe and chronic forms of tuberculosis often need the help of several specialists. The following is a clinical example:

Patient K., 43 years old, group II disability on tuberculosis. Diagnosis: Inflammatory stage of fibrous-hollow tuberculosis of the upper and middle part of the right lung, tuberculosis rod (ST) +, chronic pleural empyema with bronchopleural effusion, isoniazid, rifampicin, streptomycin, ethambutol, kanamycin, protionamide , resistance to capreomycin and levofloxacin; Type 1 diabetes mellitus, severe course, period of decompensation; chronic viral hepatitis C; HIV infection. Charlson’s comorbidity index is 7 points. Clinical anxiety and depression cases were identified on the HADS scale. In such cases, the treatment of the patient requires the assistance of several specialists, such as a phthisiologist, infectious disease specialist, endocrinologist, chest surgeon, psychotherapist. [15]

CONCLUSION

Patients with severe forms of tuberculosis need the help of several specialists at the same time, ie therapist, infectious disease specialist, cardiologist, endocrinologist, surgeon, neurologist, due to the existing comorbidities in them. Such patients will also need the help of a psychotherapist as anxiety and depression are clearly developed. In summary, treatment of patients with severe and chronic forms of tuberculosis requires palliative care, including medical and psychological interventions.

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