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Medical and Social Aspects of Palliative Care for Dementia

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Annotation: In the context of aging of the population, the volume and complexity of problems that need to be solved in order to meet the need for help and support of the elderly increases. The number of elderly people with dementia is increasing. Dementia is one of the main causes of disability and inability to live on their own in older people around the world. This seriously affects not only the patients themselves, but also their families and caregivers. Dementia is a syndrome characterized by impaired memory, impaired thinking and behavior, and decreased ability to perform daily activities. Although dementia mainly affects older people, it is not part of the normal aging process.

Keywords: Dementia, palliative care, medical and social aspects, care.

Introduction. In 2002, the World Health Organization proposed a new revision of the definition of palliative care and identified it as a treatment method aimed at improving the quality of life of patients and their families with problems related to life-threatening diseases. This approach is done by preventing and alleviating suffering through early diagnosis, accurate assessment and treatment of pain and other problems and symptoms – physical, psychosocial and spiritual disorders.

Palliative care:

- this will relieve pain and other symptoms that can cause suffering;
- the Tsar confirms life and perceives death as a natural process;
- does not seek to accelerate or delay the onset of death;

- this includes the psychological and spiritual aspects of patient care;
- the patient is offered a support system that helps them live as actively as possible until death;
- it offers a system of support for the patient's loved ones during illness, as well as during loss;
- it uses a collective approach to meet the needs of patients, including providing psychological advice to relatives of the patient after leaving, if necessary;
- improves the quality of life and can have a positive effect on the development of the disease;

it is used at an early stage of treatment in combination with other types of therapy designed to prolong life, such as chemotherapy or radiation, and includes the necessary examinations to better understand and manage the clinical complications that cause suffering. While palliative care remains a relatively new component of modern medicine, it is increasingly recognized as one of the integral components of any health care system. At the same time, such a need only increases due to the fact that the use of Hospice and palliative care does not correspond to the volume of global need, and the number of elderly with comprehensive health problems increases, taking into account the aging of the population. In most countries of the world, the need for palliative care for patients with chronic diseases that limit life expectancy is currently unresolved.

The late stage of dementia is characterized by almost complete dependence and passivity of the patient. Serious memory impairment is observed, physical signs and symptoms become more pronounced.

Such symptoms include:

- usually disorientation in time and space;
- difficulties in understanding what is happening around;
- inability to recognize relatives, friends and familiar things;
- inability to eat without help, sometimes difficulty swallowing;
- the need for assistance in performing actions related to personal hygiene is increasing (maintaining the bathroom and toilet);
- involuntary stool and urination;
- difficulty moving, loss of walking ability or can be chained to a wheelchair or bed;
- changes in behavior can increase and include aggression towards the caregiver, non-verbal agitation (kicking, kicking, loud screaming or moaning).;
- inability to move at home.

Thus, the burden on caregivers increases significantly, since the patient becomes completely dependent and loses the ability to report his needs and desires. He often needs:

- ✓ Provide 24-hour care, support and control;
- ✓ full nutrition assistance;
- ✓ full physical care (toilet, bathroom, dressing, movement);
- ✓ management of behavioral problems.

Changes in physical, psychological state and/or social conditions in some cases require the placement of elderly people in long-term care facilities, psychiatric hospitals, since they can no longer independently provide independent care. After a while, in the conditions of these institutions, they will need palliative care and help for the rest of their lives. In the last year of life, about 1.65% of patients in need of palliative care suffer from Alzheimer's disease and other dementia, which is about 317,275 people worldwide, according to the world atlas of palliative care.

The development of palliative care in long-term care facilities and psychiatric hospitals is becoming increasingly common. At the same time, in order to achieve high-quality palliative care in these institutions, cooperation with trained personnel and external specialists, volunteers and relatives is necessary.

Currently, there is strong evidence that palliative care is insufficient for people with dementia, especially at the end of their life [7, 8]. Retrospective study of disease history makes it clear that PMP is inadequate in psychiatric and acute inpatient departments [9]. The results of studies in the US and Israel also confirm a very oppressive picture [10, 11].

During a retrospective survey of caregivers, a set of symptoms and signs appeared in patients with dementia in the last year of life was found: confusion in 83% of those observed, urinary incontinence in 72%, pain in 64%, mood reduction in 61%, constipation in 59% and loss of appetite in 57% of patients [12, 13]. Chronic elderly patients due to polymorbidity often have joint health conditions of varying degrees in the last phase of life. Despite the peculiarities of the symptoms of certain diseases, many clinical manifestations and functional disorders characteristic of the last years of the life of an elderly patient are almost identical in various diseases of their terminal stage. Often, I. J. According to Higginson, such disorders are: confusion, insomnia, depression, pain, loss of appetite, difficulty breathing, constipation, vomiting, anxiety state in the patient and people who help him [14].

Significant difficulties in assessing the condition of patients arise when confusion arises against the background of prolonged dementia, when it is difficult to determine the predominance and severity of the symptoms of intellectual-Mnestic and psychopathological diseases. Patients with Mnestic and intellectual manifestations of dementia who are not mentally retarded can live longer. Their condition worsens and a decrease in the level of functions occurs gradually and steadily over a long period of time [15-21]. From diagnosis to death, their average life expectancy is about 8 years. During this time, the need for palliative care and the dependence of patients on others is increasing, although the patients themselves do not report it to themselves, which is very traumatic to the people who care for them. Taking into account the incorrect level of palliative care in both long-term institutions and specialized hospitals and the inability of patients with dementia to access specialized palliative care services, it can be concluded that patients need palliative care, especially palliative care. last year of life-not satisfied [22-26].

Currently, not only one model has been developed, but there is no scientific data in favor of the effectiveness of palliative care for severe dementia, which confirms the need to study this topic. In addition, it is important to determine the general criteria for sending the patient to a medical organization that provides palliative care, including in a hospital [27-31]. Paragraph 12 of the order states that, with the exception of patients with malignant neoplasms, the referral of patients to medical organizations providing palliative care is carried out by the decision of the Medical Commission of the medical organization, where the observation and treatment of the patient is carried out.

Materials and methods. In the analysis of data, reporting documents of the psychiatric hospital of the Samarkand region were used, using statistical, sociological, analytical research methods.

Prior to statistical analysis, the collected material had to be examined and monitored for completeness and accuracy of data accounting. Data that did not meet the specified requirements were not taken into account, corrupted questionnaires were rejected, open questions were encoded, and initial data was transmitted to the database. In the process of information processing and mathematical analysis, we used applied computer programs.

Results and discussion. On the basis of Samarkand Regional Psychiatric Hospital in 2024, information about the medico-social aspects of providing palliative care for dementia, as well as the physical health of this group of patients, was studied. The group under consideration included 55 patients, of whom 24 were men and 31 women, with a median age of 67,3 years for women and

56,8 years for men. In the process of being in the department, 9 patients were registered and admitted to psychoneurological internships, 1 was sent home, 5 were transferred to the city gkb in connection with the exacerbation of joint diseases. It should be noted that 2 of those transferred to the gkb died in specialized departments.

The analysis showed that some aspects of the physical health of patients require more attention with the development and appearance of specific signs and symptoms of dementia. The overall level of activity requires attention. In the final stages of dementia, the loss of body weight becomes apparent. Thus, in 30% of patients during the analysis, the loss of body weight has increased by more than 48% since the diagnosis. Thus, it is necessary to look for ways to treat the general fatigue of the patient, for example, the use of various feeding methods so as not to deteriorate. Constant loss and inactivity of body mass and muscle mass increases the risk of developing secondary changes in the form of contractures and violation of the integrity of the skin.

It is noted that severe dementia symptoms are combined with dysfunction of the pelvic organs. Urinary incontinence was reported in 86% of patients. Constipation, which in turn can lead to delay or urinary incontinence due to an overflow of the bladder, has been observed in 74% of cases. The causes of constipation can be poor nutrition, insufficient fluid intake, as well as the use of certain medications. Inactivity and a decrease in cravings for feces only aggravate the problem, causing discomfort and pain. During the study, a feeling of discomfort against the background of constipation was found in 40% of patients and pain in 30.5%. In 40.2% of patients, there was an increased state of confusion or arousal. In 92% of patients, a state of confusion was reported and in 54% the mood decreased.

Chronic elderly patients due to polymorbidity often have joint health conditions of varying degrees in the last phase of life. Despite the peculiarities of the symptoms of certain diseases, many clinical manifestations and functional disorders characteristic of the last years of the life of an elderly patient are almost identical in various diseases of their terminal stage. Often, I. J. according to. Higg-a person, such diseases: confusion, insomnia, depression, pain, loss of appetite, difficulty breathing, constipation, vomiting, anxiety in the patient and in people who help him.

Eliminate pain and other symptoms. The development of palliative care helps to apply the principles of controlling pain syndrome and other symptoms more broadly. At the same time, at all stages of care, additional efforts are required to improve the qualifications of all medical specialists in assessing, monitoring and eliminating pain syndrome and other painful manifestations of the disease.

Numerous studies have shown evidence of symptom prevalence, including pain syndrome in a variety of diseases in patients with a lifetime. Thus, pain syndrome is observed in 47% of patients at the end of life in Alzheimer's disease and other dementia. Identifying and assessing pain syndrome in people with severe dementia is a serious problem. The results of a number of studies have shown that 71% of patients with an average mental state of 20,7 on the mmse scale experienced pain for some time, 47% occasionally appeared and 24% were constant. Only 15% of those who experienced pain received pain relievers. According to another study, more than 25% of patients experienced pain every day, of which only 25% received pain relievers. In the course of the study we conducted, weak pain syndrome evaluated on the painted scale was reported in 63% of cases, but the prescription of pain medication therapy was reported in 42%.

According to some data, doctors do not always recognize pain in people with dementia and, as a result, do not always take adequate measures to eliminate it. In a study of elderly patients, after a hip fracture, it was concluded that those who could not talk about their pain prescribed less pain relievers. There are the most alarming reports that patients without cognitive impairment received three times more opioid analgesics than patients with severe dementia. It was also found that individuals with cognitive impairment were prescribed less pain relievers in the postoperative period. This data increased interest in pain assessment tools. Self-filling scales have been useful in people with mild to moderate dementia who are still able to provide information. Means for monitoring the manifestation of pain allow you to catch not only pain, but also pain, one of the reasons for which may be pain. In patients who cannot communicate, the task of preventing and stopping pain is complicated by the lack of a simple and reliable means of assessing its intensity.

Thus, in the study we conducted, the determination, assessment and monitoring of the severity of pain syndrome was carried out using the pain assessment scale in PAINAD severe dementia.

Conclusions. Thus, a study conducted showed that careful and careful monitoring by the average medical staff of patients with a severe form of dementia, as well as regular medical examinations, allows timely detection, assessment and correction of painful symptoms, including pain syndrome, which leads to an improvement in the quality of life of patients keladi.va their families.

In order to properly and timely organize the provision of palliative care for dementia, it is necessary to take into account the physical condition of the patient, as well as the presence of pain.

It is recommended to distinguish three signs of abuse to send the patient to a palliative care medical organization for consultation or observation. The first is the determination of functional activity (Bartel scale, FAST) if a person cannot walk, engage in meaningful conversation and depend on many types of daily life, especially since it is the loss of more than 10% of body weight in the last 6 months, repeated infections and many namins (callus abscess); the second is a fracture of the thigh or pneumonia in advanced dementia;

The main thing is to decide to continue working and understand that the lack of palliative care leads to excessive suffering of the most vulnerable people. Palliative care fully meets the goals of helping people with dementia to receive care that is administered to the patient and is effective in terms of care. palliative care should be provided, in particular, at the last stage of the disease, by clinicians or other specialists with knowledge and experience in possible issues (for example, pain, refusal of food and drink, inability to swallow and caregivers– a complex of mental symptoms, adaptation to the idea that the disease is caused by the loss of a loved one and cannot be cured).

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