SOME CRISES IN PALLIATIVE CARE

Genuine physical crises in palliative care in malignant disease are not particularly common in General Practice.

None the less it is very important to consider the possibility of an underlying serious problem in certain presentations (e.g. confusion, sudden onset back pain or headache)

In the community, it is also of paramount importance to consider whether admission for aggressive management is indicated or whether the patients overall condition is such that it is more appropriate that they should simply receive continuing palliative care in their home.

HYPERCALCAEMIA

* Symptoms
	+ Fatigue
	+ Pain
	+ Nausea and vomiting
	+ Confusion
	+ Anorexia
	+ Constipation
* Signs
	+ Difficult to distinguish from general deterioration
	+ Sometimes mimic opioid toxicity
* Management
	+ Check adjusted calcium if treatment felt appropriate
	+ Admission for i/v rehydration & i/v bisphosphonates

MALIGNANT SPINAL CORD COMPRESSION

* Early symptoms
	+ Pain
	+ Severe local spinal pain (8/10)
	+ Pain in upper or mid spine
	+ Pain worse at night
	+ Pain worse on straining
	+ Radicular pain
* Late symptoms
	+ Weakness
	+ Sensory disturbance
	+ Autonomic problems (bladder / bowel)
* Signs
	+ Spinal tenderness
	+ Weakness / Difficulty walking
	+ Sensory loss
* Management
	+ Urgent admission – supine (unless felt to be too frail for aggressive management)
	+ Dexamethasone 16mg/day

SUPERIOR VENA CAVAL OBSTRUCTION

* Symptoms
	+ Headache
	+ Feeling of ‘fullness’ in head
* Signs
	+ Oedema of face and arms
	+ Dusky colour of skin and distended superficial veins
	+ Breathlessness (worse lying flat)
* Management
	+ Admission
	+ Dexamethasone

TERMINAL AGITATION

* Management
	+ Exclude treatable causes (e.g. retention, impaction, poorly controlled pain, opioid toxicity) if possible.
	+ Relieve treatable causes
	+ If opioid toxicity suspected reduce dose by 50% and observe
	+ Midazolam 2-5mg s/c bolus as required
	+ Commence midazolam s/c infusion

RAISED INTRACRANIAL PRESSURE

* Symptoms
	+ Persistent headache worst in morning
	+ Vomiting
	+ Seizures
* Signs
	+ blood pressure
* Management
	+ Dexamethasone 16mg/day
	+ Symptom relief
	+ Consider admission for further therapy

HAEMOPTYSIS

* Management
	+ Consider cause (e.g. tumour erosion / infection / PTE)
	+ Oral steroids
	+ Antifibrinolytics
	+ Antibiotics (if infection suspected)
	+ Suction
	+ Consider admission

HAEMATEMISIS

* Management
	+ Consider cause (e.g. tumour erosion, drug side effect)
	+ Consider admission

CATASTROPHIC BLEEDING e.g. HAEMOPTYSIS / HAEMATEMISIS / CAROTID ARTERY EROSION

* Management
	+ If ‘expected’ terminal event prepare patient and family as much as possible
	+ Position probably best sitting forward well supported
	+ Towels
	+ Midazolam 10mg i/v or i/m
* More important for someone to be with patient than leaving to get drugs

STRIDOR

* Management
	+ Consider cause
		- Intrinsic obstructing lesion or extrinsic compression from adjacent structure e.g. thyroid
	+ If expected part of disease progression (head and neck cancer) prepare patient and carer and ascertain wishes if possible
	+ Immediate management steroids (dexamethasone 16mg) / adrenaline nebules
* Place of care
	+ If tracheostomy is an option
		- Emergency admission for definitive procedure to alleviate obstruction
	+ If tracheostomy not an option & clear end of life event
		- Midazolam 10mg i/v or i/m